



ed.
7

INDEX
TO
THE MODERN HOSPITAL

VOLUME XI

JULY TO DECEMBER, INCLUSIVE
1918



299639
2:5:34

PUBLISHED BY
THE MODERN HOSPITAL PUBLISHING CO., Inc.
CHICAGO, ILL.

64
2127
M
1
1-2

THE
MODERN HOSPITAL

EDITORS

HENRY M. HURD

FREDERIC A. WASHBURN

WINFORD H. SMITH

S. S. GOLDWATER

W. L. BABCOCK

JOHN A. HORNSBY

M. K. CHAPIN,
Managing Editor.

INDEX

This index contains in a single alphabetical sequence the names of authors and subjects of all articles published in THE MODERN HOSPITAL during the six months covered by this volume. The following abbreviations indicate special departments in which articles appeared: Ab., abstract in Current Hospital Literature; Bk. Rev., Book Reviews; Corr., Letters to the Editor; Ed., Editorials; Q. and A., Queries and Answers.

A

Accounting Committee of American Hospital Association, Report of.....	336
Accounting, Hospital—Porter, Charles A.....	102, 173, 266, 371, 413
Adler, Eleanor—An Experimental Employment Bureau for Cripples.....	402
Administrative Articles.....	
Economy Campaign, Cooperative, in all Departments of the Hospital—Bacon.....	430
Economy Problem, War-Time, in the Hospital—Devan.....	445
Efficiency System for Medical Work of State Hospitals—Singer.....	260
Food Waste in Hospitals—Pitlor.....	491
Fuel, Saving of, in Hospitals—U. S. Fuel Administration.....	230
Heating and Power Plant Economies for Hospitals—Kimball.....	457
Hospital Administration, Discussion by Massachusetts Medical Society.....	181
Hospital Management, Some Problems of—Tuley.....	153
Hospitalism—Its Causes and Treatment—Clark.....	53
Housekeeping, Hospital, Its Worries and Cares—Jamieson.....	15
Laundry System which Has Proved Successful—Fish.....	43
Medical Staff, Resident, Self-Government for—Bacon.....	47
Visitors and Visiting in Hospitals—Geffen.....	61
Admitting Desk, Friendly Relations with Patients Established at.....	203
Adolescent Clinic of Stanford University Medical School, Work of, (Ab.)—Gates.....	151
Advertising the Public Sanitarium—Gammons.....	109
Aeroplanes, Radio-Chemical Laboratory and.....	409
After Care of Disabled Men, Inter-Allied Conference on.....	210
Agatha Hospital, Clinton, Iowa.....	29
Agostini, C.—The Economic Problem of the Italian Hospitals for the Insane (Ab.).....	152
Alder Hey Military Orthopedic Hospital.....	375
Ambulance, Trolley Hospital, First.....	105
American Association of Hospital Social Workers.....	205
American Association of Industrial Physicians and Surgeons, Thirty-first Annual Meeting of.....	133
American Dietetic Association, Atlantic City Meeting of.....	306, 405
American Home Economics Association, Meeting of.....	113
American Hospital, Chicago.....	284
American Hospital Association, Bulletin of.....	35, 126, 227, 472
Institutional Membership in, Advantages of (Ed.).....	460
Twentieth Annual Convention, Announcement of.....	227
Twentieth Annual Convention Commercial Exhibit.....	227
Twentieth Annual Convention, Editorials on.....	188, 256
Twentieth Annual Convention, Report of.....	310
American Medical Association, Sixty-ninth Annual Session of.....	130
American Medico-Psychological Association, Seventy-fourth Annual Meeting of.....	45
American Nurses' Club in London.....	417
American Public Health Association, Meeting, Announcement of.....	409
Influenza Cause, Postponement of.....	409
American Women's Hospitals—Conger.....	68, 346
American Women's Hospitals in France, Work of.....	418
Auckel, Arthur B.—The War and the Civil Hospitals in the Reserves (address).....	327
Aesthetic Screen.....	348
Architectural Articles.....	
Ashland General Hospital, Ashland, Wis.—Dodd.....	264
Barlow Sanatorium, New Four-Patient Cottage at—Klotz.....	378
Brookville General Hospital, Brookville, Pa.—Bailey.....	165
Buffalo General Hospital, Memorial Hall at—Stevens.....	20
Construction, Details of—Perry.....	469
Hackensack Hospital, Nurses' Home of—Washburn.....	84
Tuberculosis Sanatorium Buildings, Small, Planning of—Burt.....	1
Vancouver General Hospital, Military Annex of—MacEachern.....	257
Argentina, Anti-Tuberculosis Work in—Coni (Ab.).....	490
Army General Hospital, U. S., 2,500-Bed, to be Built in 100 Days.....	309
Army Litter, Field and Hospital Use for.....	70
Army Nursing, Program of—Goodrich.....	410
Army Nursing Question (Ed.).....	139
Army School of Nursing.....	50
Army School of Nursing and the Civil Hospital.....	290
Army School of Nursing, Camp—Fadsworth, S. C.....	413
Ashland General Hospital, Ashland, Wis.—Dodd.....	264
Atlantic City Meeting of American Hospital Association.....	188, 227, 286, 310, 383
Attendant, Trained—Dakin.....	198
Audit Committee of American Hospital Association, Report of.....	329
Australian Institutions, Purchasing Methods Adopted by (Corr.)—MacLennan.....	346

B

Bacon, Asa S.—Cooperative Economy Campaign in All Departments of the Hospital.....	430
Bacon, Charles B.—Self-Government for the Resident Medical Staff.....	17
Bahama General Hospital and Asylum—Milne.....	376
Bailey, Emmet E.—How to Build an Efficient General Hospital for Small Communities.....	165
Baldy, J. M.—Has Every Hospital an Inherent Right to an Intern?.....	89
Barlow Sanatorium, New Four-Patient Cottage at—Klotz.....	378
Bas, Elizabeth and Loebner, Maud—Physical Status of Juvenile Delinquents in the Reformatory of the City of New Orleans (Ab.).....	151
Beckman, James W.—Floating Hospital of St. John's Guild Again at Work.....	92
Beckwith Hills Psychiatric Hospital, Laboratory of Social Hygiene (Ab.)—Southard and Davis.....	499
Belgium, A Message from (Ed.).....	286
Belgium, America's Help of, After the War—Sand.....	256
Belmont, Roy O.—The Problem of the French Military Hospitals (Ab.).....	469
Bellevue, France, American Hospital for the Study of Gas Cases at.....	429
Benedict, Sarah—Food Conservation in Ohio Hospital.....	206

Blaine Foreign Body Localizing Instrument.....	347
Blind, St. Dunstan's Hostel for—McCallin.....	295
Blind, Who are They? (Ed.).....	296
Blood Counting Apparatus.....	421
Bloomington Girls' Industrial Home.....	375
Blue, Rupert—Influenza, Epidemic, and the United States Public Health Service.....	123
Blue Cross Hospital for Horses—Forward and Lees.....	349
Blue Triangle Hut—Nissley.....	416
Bologna, Institute of Reeducation for Crippled Soldiers (Ab.).....	476
Bookkeeping, Hospital—See Accounting.....	336
Books Received for Review.....	224, 346, 498
Book Reviews.....	498
Boschi, G.—The Hospital for Nervous Diseases Villa del Seminario at Ferrara (Ab.).....	223
Bowditch, W. Y.—A Children's Pavilion at the Sharon Sanatorium (Ab.).....	222
Bowen, A.—Standardization of State Hospitals.....	82
Bowman, John G.—The Business of Medicine and the Profession of Medicine.....	123
Bradshaw, Emerson O.—Influenza Relief Work of Stock Yards Community Clearing House (Corr.).....	497
Brazil, Eugenes in.....	457
British Columbia, Hospitals of, First Convention of.....	136
Brooks, W. A.—Out-Door Treatment of Spanish Influenza.....	427
Brooklyn General Hospital—Bailey.....	165
Buenos Aires, Hospitalization of Pulmonary Tuberculosis in (Ab.)—Coni.....	222
Buffalo General Hospital, Memorial Hall of—Stevens.....	20
Bureau of Hospital Administration.....	35, 126, 227, 472
Bunk, Glennan Adjustable—Kerns.....	194
Bunn, F. S., Death of (Ed.).....	465
Burnette, Norman L.—Occupational Therapy in Canadian War Hospitals.....	401
Burt, James D.—The Planning of Small Tuberculosis Sanatorium Buildings.....	1
Butterfield, C. L.—Hospital Housekeeping and War-Time Economies.....	220
Byrne, Miriam—Methods of Indexing Hospital Clinical Records.....	86

C

Cabot Course of Case Records—Painter.....	355
Cabret, D.—The New Tuberculosis Sanatorium "Santa Maria" (Ab.).....	238
Camp Sevier, Food Conservation in.....	51
Canadian Civil Hospitals' Part in War Work—MacEachern.....	257
Canadian National Association of Trained Nurses and Canadian Association of Nursing Education, Meeting of.....	46
Canadian Rehabilitation and Reconstruction Work—Kidner.....	393
Canadian Red Cross, Work Accomplished by, in 1917.....	402
Canadian War Hospitals—Occupational Therapy Bureau.....	401
Carry On.....	211
Carter, Herbert K. and Porter, Charles A.—Hospital Accounting.....	102, 173, 266, 371, 413
Case Studies.....	355
Cassette, McIntosh X-Ray "Verithin".....	80
Catholic Hospital Association, Report of Third Annual Meeting of.....	120
Chapin, M. K.—Hospitals and Hospital System of China.....	410
Chart Rack, Sacred Heart Hospital, Fort Madison, Iowa.....	29, 112
Children's Hospitals.....	
Children's Hospital, Columbus, Ohio.....	187
Children's Hospital, Philadelphia.....	383
Children's Hospital, Washington, D. C.....	384
Floating Hospital of Saint John's Guild—Beckman.....	92
Hospital of Extended Grace to Women and Children, Poyang Yang, Korea—Hall.....	252
Children's Pavilion at Sharon Sanatorium (Ab.) Bowditch.....	222
Chile, Hospitals and Hospital System of—Chapin.....	410
Chile, Hospitals of (Ed.).....	463
China, North, Pitiable Condition of Insane in (Ab.)—Ingram.....	152
Chinese Women's Hospital, Work in (Corr.)—Murdoch.....	345
Cincinnati Public Health Council—Dinwiddie.....	180
Civil Hospitals.....	270
Clark, Pliny O.—Hospitalism—Its Causes and Treatment.....	53
Cleveland Hospital Council, Purchasing Bureau of.....	107
Clinic, Training School for French Military Hospitals (Ab.).....	436, 451
Clings, Venereal Disease—Davis.....	436
Coal, Spontaneous Combustion of (Ed.).....	192
Community Hospitals.....	
Ashland General Hospital—Dodd.....	264
Brookville General Hospital—Bailey.....	165
Kerrville Sanatorium Hospital—Harrison.....	58
Community Hospitals, Efficient, General, Problem of Building of.....	165
Community Hospitals, Small, Plan for First Unit of (Ed.).....	190
Community Nurses: See Public Health Nurses.....	
Conger, Charlotte M.—Work of the American Women's Hospitals in Argentina.....	68, 346
Coni, E. R.—Anti-Tuberculosis Organization in Argentina (Ab.).....	499
The Hospitalization of Patients with Pulmonary Tuberculosis in Buenos Aires (Ab.).....	222
Conley, Emma—The Red Cross Dietician Service.....	427
Connecticut Training School for Nurses—Landis.....	407
Connecticut Training School of New Haven Hospital, Vacation for.....	344
Conservation: See Drugs; Conservation of; Economy; Food Conservation; Fuel Conservation; Gauge, Conservation of.....	
Construction, Hospital, Details of—Perry.....	469
Convalescent, Care of, in the Hospital—Maggiore di Milani (Ab.).....	191
Ronzani.....	152
Corn, Sweet, Preparation of, and Drying.....	143
Cottage Hospital, Creston, Iowa.....	112
Cott, John, and Co., Inc., for French Military Hospitals (Ab.).....	224
County Hospital, Jefferson, Fairfield, Iowa.....	387
County Jails of Illinois—Hinrichsen.....	353

Cox, Simon F.—Vacation Shore Cottage for Nurses.....	344
Crawford, Charlotte H.—Life-Saving Surgical Dressing Squads in France.....	178
Creston, Iowa, Scheme for Rural Hospitalization in (Corr.)—Kapp.....	200
Crippled: See also Disabled.	
Crippled Men, American School of Rehabilitation for—McMurtree.....	75, 145
Crippled Soldiers: Institute of Reeducation for, in Bologna (Ab.).....	476
Cripples, Experimental Employment Bureau for—Adler.....	402
Cubic Feet per Patient in Isolation Hospital (Q. & A.).....	420
Current Hospital Literature.....	151, 222, 499

D

Dakin, Florence—The Trained Attendant.....	198
Dark-Room Ventilator, Light-Proof.....	500
Davis, Michael M., Jr.—Venereal Disease Clinics.....	456, 481
Davis, Michael M., and Warner, Andrew R.—Dispensaries, Their Management and Development (Bk. Rev.).....	498
Who Should Be Dispensary Patients?.....	64
Davis Suprapubic Drainage Bottle.....	225
Dayton State Hospital, Mental, Dayton, Ohio.....	225
De Molle, Katherine—How the American Red Cross in France Monks Mutilated Faces.....	158
De Paoli, G.—Male Divisions Intrusted to Female Nurses in Hospitals for the Insane (Ab.).....	223
Dehydrated Vegetables and Fruits.....	142
Delano, Jane A.—The Nursing Program of the American Red Cross.....	336
Delinquents, Juvenile: Physical Status of Based on Examinations of Children in Reformatories of New Orleans—Bass and Loeber.....	151
Dench Anesthetic Screen.....	348
Devenish Manufacturing Company, Heat Work of—Weler.....	458
Thomson Alan—War-Time Economy Problem in the Hospital.....	445
Diabetics, Gluten Flour for.....	308
Diet and Nutrition, Latest Books on.....	208
Dietary Department of Hospital, Management of Graves.....	394
Dietetic Association, American, Meeting of.....	306, 406
Dietetics, Department of.....	51, 142, 206, 306, 406, 498
Dietetics, Nurses' Course in.....	308
Dietician in Social Service—Weler (Ed.).....	189
Dietitian Problem in the Small Hospital (Q. & A.).....	79
Dietitian Service, Red Cross—Conley.....	407
Dietitians, College Course for.....	408
Dietitians, News Notes of.....	209, 409, 496
Dietitians' Question Box.....	308
Disabled: See also Crippled.	
Disabled, Agriculture for.....	74
Disabled Men, Hostels for, in London.....	50
Disabled Soldiers and Sailors, Human Factors in the Reconstruction of—McMurtree.....	476
Disabled Soldiers, Sailors and Marines, Aid for—Pennsylvania.....	297
Dispensaries, Disreputable, Massachusetts Finds Remedy for.....	73
Dispensaries, Their Management and Development—Davis and Warner (Bk. Rev.).....	498
Dispensary and Out-Patient Work.....	73, 145, 481
Dispensary Patients, Admission of—Davis and Warner.....	64
Distilled Water: See Water Still.....	264
Dodd, J. M. The Ashland (Wis.) Community Hospital.....	264
Doulass, Stephen A.—The State Sanatorium and the Labor Problem.....	99
Drainage, Suprapubic, Vacuum Bottle for.....	225
Dressing Station, British, Advanced, On Newly Captured Ground.....	88
Drew, Charles A.—The Standardization of Hospital Work.....	66
Drugs and Other Supplies, Conservation of—MacEachern.....	142
Dried Vegetables and Fruits.....	142

E

East Haven Hospital, Richmond, Indiana.....	385
Economies, War-Time, and Hospital House-keeping—Butterfield.....	220
Economy: See also Conservation.	
Economy Campaign, Cooperative, in All Departments of the Hospital—Bacon.....	430
Economy Problem, War-Time, in the Hospital—Devan.....	415
Editorials.....	30, 114, 188, 286, 386, 460
Educational Work for Children at Lakeside Hospital—Warner.....	354
Edward L. Trudeau Institution in France—White.....	247
Epidemic Synthesis for Hospital Work of State Hospitals—Singer.....	150
Electric Warming Pad, Safety.....	233
Electrothermal Applicators.....	422
Eiel Blood-Counting Apparatus.....	421
Epiz, Reconstruction Hospital Presented to Government by.....	344
Elm City Hospital, New Haven, Connecticut.....	284
Emery University, Atlanta, Georgia, Syphilis Clinic of (Ab.).....	152
Emery, W. B.—Syphilis Clinic of Emory University, Atlanta, Ga. (Ab.).....	152
Employment Bureau for Cripples—Adler.....	402
Epileptics, Institutions for the Care of—Shanahan.....	374
Episcopal Hospitals, Histories of: Report of.....	437
Eugenics in Brazil.....	437
Evangelical Deaconess' Hospital, Marshalltown, Iowa.....	29

F

Facial Mutilations: See Mutilations, Facial.	
Farm, Garden and Dairy, Institutional Consultant for (Corr.)—Hobbs.....	202
Farmer, W. S.—Mrs. Peggy Ann Sutton and Her Quilt (Corr.).....	200
Feeble-Minded Inmates of New York Institutions, to be Shifted Out of Five Editors' New Record.....	458
First, June—Dietary Studies Made in the Missouri State Hospitals for the Insane.....	306
Fish, Lina Stryker—Laundry System Which Has Proved Successful.....	433

Floating Hospital of Saint John's Guild Again at Work—Beckman.....	92
Food Conservation in Military Hospitals.....	51
Food Conservation in an Ohio Hospital—Benedict.....	306
Food Conservation in Hospitals (Ed.).....	289
Food Waste in Hospitals—Pitcher.....	191
Foreign Bio Localizing Instrument.....	347
Forward, Charles W., and Lees, George Frederick—At The Sign of the Blue Cross.....	349
France, Organization of Tuberculosis Work for Soldiers in (Ab.).....	498
Fraternat Institution for the Free Treatment of Tuberculosis—Rutledge.....	155
Freyberg Light-Proof Dark-Room Ventilator.....	500
Fruits and Vegetables, Dehydrated.....	142
Fuel and Power Plant Economies for Hospitals—Kimball.....	437
Fuel, Conservation of, in Hospitals—U. S. Fuel Administration.....	250

G

Gage, Harriet—Friendly Relations with Patients Established at Admitting Desk (Corr.).....	203
Gammons, Herbert F.—Advertising the Public Sanatorium.....	409
Gas Cases, American Hospital for the Study of, Bellevue, France.....	429
Gaspe, Andin A.—The Work of the Adolescent Clinic of Stanford University Medical School (Ab.).....	151
Gauze and Bandage Cutting Machine.....	225
Gauze, Conservation of—Shilt.....	66
Gauze Dressings, Knitted.....	447
Gauze Rolling and Folding Machine.....	421
Geffen, Joseph—Visitors and Visiting in Hospitals.....	61
Gelatine Food Products Recognized by U. S. Food Administration.....	409
Gelatinous Food, S. Vague of.....	308
Genoa, Neurological Center of the Territorial Army at (Ab.).....	499
George F. Geisinger Memorial Hospital, Danville, Pennsylvania—Robinson.....	181
Girls, Societies, Private Institutions of—Bloomington, Ill.....	275
Glennan Adjustable Bank—Kerns.....	194
Gluten Flour for Diabetics.....	308
Goff, J. R.—The Woman's Hospital in the State of New York.....	222
Goldwater, S. Hospital Disinfection or Hospital Conservation—Which? (Ed.).....	30
Patriotic Duty of Hospitals During the War (Ed.).....	115
Report of the War Service Committee, American Hospital Association, Meeting, Atlantic City, New Jersey.....	332
Goodrich, Annie W.—The Nursing Program of the Army.....	410
Goodwill Electric Heating Pad.....	422
Grant Hospital, Chicago—Robinson.....	25
Grant Hospital, Columbus, Ohio.....	28
Grant Hospital, Columbus, Ohio—Robinson.....	183
Graves, Lulu G.—The Management of the Dietary Department of the Hospital.....	394
Gray, Carolyn E.—Vassar's Response to the Nation's Need for Nurses.....	204

H

Hackensack Hospital, Nurses' Home of—Washburn.....	84
Hackley Hospital, Muskegon, Mich.....	284
Hall, Joseph—The Hospital of Extended Grace to Women and Children.....	253
Hamilton, Eleanor E.—A Plea for the Hourly Nursing Service as a War Measure (Corr.).....	78
Harp, Joseph—Detroit, Mich.....	29
Harrison, Margaret—The Community Hospital as Viewed by a Nurse.....	58
Health and Modern Industry.....	299, 418, 488
Health Insurance—Howell.....	414
Health Insurance and Hospitals—Lapp.....	398
Health Insurance and Its Relation to Hospitals—Howell.....	466
Health Insurance, Its Medical and Hospital Aspects—Lapp.....	160
Heat and Light Infuser, Thermolite.....	153
Heat Applicators.....	422
Heating Plants: See Fuel.	
Helen C. Juilliard, Floating Hospital.....	92
Heliography and X-Rays in the Treatment of Surgical Tuberculosis.....	263
Heliotherapy, Treatment of External Tuberculosis by (Ab.).....	476
Hersey, Thomas L. Lee—Influenza Relief Work of Pusey and Jones' Hospital.....	490
Hibbs, Henry H.—The South's First School of Social Work and Public Health Nursing.....	147
Hinrichsen, Annie—The County Jails of Illinois.....	358
Hobbs, Charles T.—The Institution Farm, Garden, and Dairy Consultant (Corr.).....	202
Hominy, Hospitals Making Their Own.....	143
Horses, Blue Cross Hospital for—Forward and Lees.....	349
Hospital Accounting: See Accounting, Hospital.	
Hospital Administration: See Administration, Hospital.	
Hospital Association: See American Hospital Association; British Columbia Hospital Association; Catholic Hospital Association; Minnesota Hospital Association; New Jersey Hospital Association.	
Hospital Bed, Railway, Glennan Adjustable—Kerns.....	194
Hospital Construction: See Architectural Articles.	
Hospital Congregation: See Hospital, Which? (Ed.)—Goldwater.....	30
Hospital Executives, Red Cross, Needed for (Ed.).....	34
Hospital, General, Organization of Ochener.....	124
Hospital Life: See Life, Hospital.	
Hospital, Medical and Special Meetings.....	43, 130
Hospital of Extended Grace to Women and Children, Pyeng Yang, Korea—Hall.....	252
Hospital, Past, Present and Future—Monroe.....	292
Hospital, Vital Issues to be Decided by (Ed.).....	117
Hospital Records: See Records, Hospital.	
Hospital Ships: See Floating Hospitals; Ships, Hospital.	
Hospital Social Work: See Social Workers, Hospital.	
Hospital Staff: See Staff, Hospital.	
Hospital Tent: See Tent, Hospital.	
Hospital Train: See Train, Hospital.	

Hospitals: See also Children's Hospitals; Community Hospitals; County Hospitals; Insane Hospitals; for Mental and Nervous Diseases, Sanatoriums for; Military Hospitals; Red Cross Hospitals; Small Hospitals; State Hospitals; Tuberculosis Hospitals.	
Hospitals, Civil, and Allied Institutions, Mobilization of, for National Service (Ed.)	31
Hospitals, Civil, and the War—Ancker	327
Hospitals, Conditions of, for	113
Hospitals, Individual, Descriptions of	113
Ashland General Hospital, Ashland, Wis.—Dodd	264
Bahama General Hospital and Asylum—Milne	376
Brookville General Hospital, Brookville, Pa.—Bury	165
Buffalo General Hospital, Memorial Hall of—Stevens	20
Edward L. Trudeau Institution in France—White	247
Floating Hospital of Saint John's Guild—Beckman	92
George F. Geisinger Memorial Hospital, Danville, Pa.—Robinson	281
Grant Hospital, Chicago—Robinson	23
Grant Hospital, Columbus, Ohio—Robinson	183
Hospital of Extended Grace to Women and Children, Pyeng Yang, Korea—Hall	252
Kerrville Sanitarium Hospital, Kerrville, Texas—Harrison	53
St. Anthony's Hospital, Carroll, Iowa—Robinson	103
Hospitalism—Its Causes and Treatment—Clark	53
Hospitalism, Practical Remedy for—MacEachern	381
Hospitalization, Rural, A Scheme for, Creston, Iowa (Corr.)—Kempford	200
Hot-Air Apparatus	154
Housekeeping, Hospitals, Its Worth and Cares—Jamieson	156
Howell, Thomas—Health Insurance and Its Relation to Hospitals	466
Workmen's Compensation, Health Insurance and Hospitals	414
I	
Ibarriz, Hospital in, for External Tuberculosis (Ab.)	497
Illinois, County Jails of—Hinrichsen	358
Illinois Course for Community Nurses	49
Immigrant, Health Standards and Care for	130
Indianapolis City Hospital	381
Indianapolis Methodist Hospital	385
India, Red Cross Work in	168
Industrial Welfare, Department of: See Health and Modern Industry.	
Industrial Welfare, Proposed Federal Control of	299
Industrial Home for Girls, Bloomington, Ill.	875
Industrial Physicians and Surgeons, American Association of, Third Annual Meeting of	133
Industrial Rehabilitation of Soldiers and Sailors; See Occupational Therapy, Vocational Rehabilitation, and Industrial Reeducation.	
Influenza Epidemic and Social Service (Ed.)	390
Influenza, Epidemic, and United States Public Health Service—Blue	423
Influenza Epidemic, Quick Action of Red Cross in	392
Influenza, Measures against	370
Influenza Relief Work of Pusey and Jones Ship-Building Company—Hersey	490
Influenza Relief Work of Stock Yards Community Clearing (Corr.)—Bradshaw	497
Influenza Situation and Hospitals (Ed.)	386
Influenza, Spanish, Out-Door Treatment of—Brooks	427
Ingram, J. H.—The Pitiable Condition of the Insane in North China (Ab.)	152
Inheritance Tax, Federal, and Hospitals (Ed.)	188
Insane: See also Nervous and Mental.	
Insane, Handwork (Cecily Ann Sutton and Her Quilt) (Corr.)—Farmer	200
Insane, Hospitals for—	
Dayton State Hospital, Mental, Dayton, Ohio	186
Kalamazoo State Hospital, Mental	458
Sheppard and Enoch Pratt Hospital, Towson, Baltimore	458
Insane in North China, Pitiable Condition of (Ab.)—Ingram	152
Insane, Italian Hospitals for, Economic Problems of (Ab.) Agostini	152
Insane, Missouri State Hospitals for, Dietary Studies in—Findley	306
Insane, Standardization of Hospitals for—Sandy	6
Insane, State Hospitals for, Male Divisions of, Intrusted to Female Nurses (Ab.)—Paoli	223
Insane, Health: See Health Insurance.	
Interns, Duties of (Q. & A.)	221
Interns in Special Hospitals, and War Service	42
Interns, Rights of Hospital to—Baldy	29
Inquiry, Memorial Hospital, Chicago—	29
Isolation Hospital, Cubic Feet per Patient in (Q. & A.)	420
Italian Hospitals for the Insane, Economic Problem of (Ab.)—Agostini	152
J	
Jails, County, of Illinois—Hinrichsen	358
Jamieson, Mary A.—Hospital Housekeeping, Its Worries and Cares	15
Java, Hospital in, for Royal Navigation Company	502
Jefferson County Hospital, Fairfield, Iowa	187
K	
Kahn, Max—The Department of Laboratories	271
Kalamazoo State Hospital, Mental	458
Kempford, Aretas E.—A Great Vision and Its Realization (Corr.)	200
Kerrville Sanitarium Hospital, Kerrville, Texas—Harrison	53
Kidney, T. B.—Canada's Rehabilitation and Reconstruction Work	393
Kimball, D. D.—Heating and Power Plant Economies for Hospitals	347
Klotz, Walter C.—New Four-Patient Cottage at Barlow Sanatorium	378
Korean War, The Nursing Program: Third-Year Training Under Government Supervision (Corr.)	292
Korean Hospital, Hospital of Extended Grace to Women and Children, Pyeng Yang—Hall	252

Labor Recruiting Agencies, Government, Medical Examination Card for	301
Laboratories, Department of—Kahn	271
Laboratories, Relation of, to Hospitals—MacCarthy	381
Laboratory Technicians, More, Needed	160
Ladd, Mr. Maynard, Work of, in Repairing Facial Defects—De Moncos	158
Lakeside Hospital, Cleveland—	
Educational Work of Children in—Warner	354
W. A. Time Economies in—Shilt	354
Landis, Maude—Connecticut Training School for Nurses	487
Lapp, John A.—Health Insurance and the Hospitals	398
Lathrop, T. S.—His Medical and Hospital Aspects	160
Latching-out	118, 192, 300
Latin America, Our Relations with (Ed.)	463
Laundry System Which Has Proved Successful—Fish	433
Lay of the Government Lady	209
Lebrede, M. G.—Necessity of Hospitalizing Typhoid Patients (Ab.)	224
Lees, George Frederick, and Forward, Charles W.—At the Sign of the Blue Cross	332
Legislative Committee of American Hospital Association, Report of	331
Letters to the Editor	78, 345, 497
Liberty Loan, Fourth (Ed.)	226
Limbless Men, Hospital for, at Cardiff (Ab.)	283
Linoleum, Battleship, How to Lay (Q. & A.)	150
Litter, Army, Field and Hospital Use for	70
Little Journeys to Places and People Worth Knowing—Robinson	23, 108, 183, 281, 454
Liverpool, Elizabeth, Hospital at	429
Loder, Cornelius S.—Report of Audit Committee, American Hospital Association Meeting, Atlantic City, New Jersey	329
Loebels, Maud and Bass, Elizabeth—Status of Juvenile Delinquents in the Reformatories of the City of New Orleans	151
Logan Sputum Cup	153
Louisville City Hospital, Organization of—Fuley	169
Louisville City Hospital, Social Service, Training of—Crispin	169
Luther, Jessie—Occupational Treatment in Nervous Disorders	11
M	
McCallin, Mrs. Sidney—Blindness a Temporary Disablement	295
MacCarthy, William Carpenter—Relation of Laboratories to Hospitals	381
MacEachern, Malcolm T.—A Canadian Civil Hospital's Part in War Work	257
Conservation of Drugs and Other Supplies	66
Practical Remedy for Hospitalized Physical and Mental Patients	379
McIntosh X-Ray Cassette	80
MacLennan, W. H.—Associated Purchase Method Adopted by Australian Institutions	346
McMurry, Douglas—Pneumonia, War, and Tramp—Crippled Men	76, 145
Human Factors in the Reconstruction of Disabled Soldiers and Sailors	476
Maimin Gause and the Army, Outage of	225
Management, Hospital: See Administration, Hospital.	
Martin, Franklin—The Volunteer Medical Service Corps	275
Maternity Hospital in Arezzo (Ab.)—Pagliani	223
Massachusetts Final Effective Remedy for Disreputable Dispensaries	73
Massachusetts Medical Society, One Hundred and Thirty-Fifth Annual Meeting of	131
Massachusetts Sick, Organized Care for (Ab.)—Whitehill	224
Maternity Hospital in Arezzo (Ab.)—Pagliani	223
Mayo Clinic, Rochester, Minn. (Ab.)—Tange	222
Mc, names beginning with; see under Mac.	
Medea, E.—The Course of Instruction for the Wounded of the World War	222
Medical Department of the Army, Economic Aspects of Program of	334
Their Effect on Civil Hospitals—Smith	334
Medical Industry Section of War Industries Board—Simpson	278
Medical Staff: See Staff, Hospital.	
Medicine, Business of and Profession of—Bowman	123
Medicine, Organized Practice of (Ed.)	116
Memoirs of a Head Nurse	60, 137, 196, 293, 391, 468
Mental Hospitals, Occupational Therapy in	196
Mental Hygiene in the War	156
Mercy Hospital, Philadelphia	385
Mercy, U. S. Hospital Ship	213
Mercy Hospital, Indianapolis	385
Miami Valley Hospital, Food Conservation in	206
Michigan State Nurses' Association, Annual Meeting of	48
Milan, Ospedale Maggiore of, Care of Convalescents in (Ab.)—Romas	152
Military Annex of Vancouver General Hospital—MacEachern	257
Military Hospitals, Food Conservation in	51
Military Hospitals, Vocational Instructors Needed in	405
Milne, Mrs. T.—The Bahama General Hospital	152
Minnesota Hospital Association, First Annual Convention of	39, 134
Missouri State Hospitals for the Insane, Dietary Studies in—Findley	306
Monroe Hospital, Conditions Editorial and Business Office of (Ed.)	118
MODERN HOSPITALS—Prospect and Retrospect (Ed.)	191
Modern Woodmen of America Sanatorium, Woodmen, Co.—Rutledge	155
Monro, A. S.—The Hospital—Past, Present and Future	292
Moulinier, Charles B.—President's Address, Catholic Hospital Association	122
Mount Carmel Hospital, Columbus, Ohio	186
Mount Sinai Hospital, New York, Nurses' Home of—Robinson	454
Moving Pictures Displayed on Camp Hospital Ceilings	177
Mutualities, Facial, Repair of—De Moncos	158
Mutualities, Facial, Work of English Sculptors in Repairing	148
N	
National Tuberculosis Association, Fourteenth Annual Meeting of	46
Nemirovsky, M. A. and Elimant, M.—Radio-Chirurgia—Aeroplane (Ab.)	499

Nervous Diseases, Hospital for, Villa del Seminario at Ferrara (Ab.)—Boschi	228
Nervous Disorders, Occupational Treatment in—Luther	11
Neurological Center of the Territorial Army at Genoa (Ab.)	439
Newell Hot-Air Apparatus	153
Newfoundland Orphan's Home at St. Anthony	63
New Haven Hospital, Vacation Shore Cottage for Nurses of—Cox	344
New Instruments and Equipment	30, 155, 225, 347, 421, 500
New Jersey Hospitals Organize	401
New York City Hospital, Self-Government for Resident Medical Staff of—Bacon	17
New York Department of Nursing and Health, Special Courses Offered by, for Teachers and Supervisors	65
New York Institutions, Feeble-Minded Inmates of, to be Sifted Out	5
New York, State of, Women's Hospital of (Ab.)—Cuffe	145
Night Supervisor, Graduate, A Necessity (Q. & A.)	150
Nissley, Clarice—The Blue Triangle Hut	416
Nurses' Aid: See also Attendant	
Nurses' Aids, A Plea from the Mount For (Ed.)	115
Nurses' Appeal for, from Red Cross Department of Nursing (Ed.)	288
Nurses' Association, Michigan State, Annual Meeting of	43
Nurses, Community, and Nurses, Public Health: See Public Health Nurses	
Nurses' Homes—	
Mount Sinai Hospital, Nurses' Home of—Robinson	454
New Haven Hospital, Vacation Shore Cottage for Nurses of—Cox	344
Nurses, Enrolment of, in the West of the United States (Ab.)	305
Nurses, Summer Preparatory Course for, at Western Reserve University—Wheeler	486
Nurses, Superintendents of, Duties of (Q. & A.)	221
Nurses, Trained, Canadian Association of, Meeting of	46
Nurses, Training of, How Colleges Can Help in—Stewart	483
Nurses, Training of, in Military Hospitals (Ed.)	114
Nurses, Vacation Cottage for—Cox	344
Nursing, Army, Enrolment of, in the West of the United States (Ab.)	305
Nursing, Department of, for, 50, 138, 204, 303, 410, 413	
Nursing in Civil Hospitals, The Relation of the War Program to—	
Netting	339
Nursing Problem: Third Year Training Under Government Supervision (Corr.)—Korndorfer	202
Nursing Program of the Army—Goodrich	410
Nursing, Public Health: See Public Health Nursing	
Nursing Resources, National War College, Meeting of (Ed.)	389
Nursing, Schools of, Standard Curriculum for—Welsh	503
Nursing, School of, Plan and Equipment of Model Teaching Unit for	138
Nursing Service, War, as a War Measure (Corr.)—Hamilton	478
Nursing, Teachers and Supervisors of, Special Courses for, Offered by New York Department of Nursing and Health	65
Nnting, Adelaide—The Relation of the War Program to Nursing in Civil Hospitals	338

O

Obstetrics and the Hospital—Paddock	291
Occupational Therapy—	
in Canadian War Hospitals—Burnette	401
in Kalamazoo State Hospital, Michigan	458
in Mental Hospitals	45
in Nervous Disorders—Luther	11
in Sheppard and Enoch Pratt Hospital, Towson, Baltimore	458
National Society for Promotion of Second Annual Meeting of	293
Occupational Therapy, Vocational Reeducation and Industrial Rehabilitation	74, 145, 210, 295, 401, 476
Ochsner, A. J.—The General Hospital	124
Ohio Hospital for the Fourth Annual Meeting of	45
Ohio State Sanatorium, Mount Vernon, Ohio, Employment of Prison Labor on—Douglass	99
Operating Room, Green, Saint Luke's Hospital, San Francisco—Sherman	97
Operating Room, Redeclaration of (Q. & A.)	150
Operating Rooms, Cleaning of, after Septic Operations (Q. & A.)	120
Operation Barrack of Board of Surgical Ambulances of the Army (Ab.)	422
Orphan's Home, St. Anthony Newfoundland	63

P

Pagliani, L.—The New Lyngs in Hospital at Arezzo (Ab.)	222
Paddock, Charles E.—Obstetrics and the Hospital	291
Parker, F. M.—Economic in Hospital	355
Painting Hospital Wards (Q. & A.)	120
Parallax Foreign Body Localizing Instrument	347
Parker Hill, Boston, Reconstruction Hospital No. 10	113
Park, Clinics, Evening, Warner of	113
Pennsylvania, Aid for Crippled Soldiers, Sailors and Marines of	297
Perry, N. V.—Details of Hospital Construction	469
Physicians, Enrolment by, Not Suspended (Ed.)	188
Physiotherapy as War Work for Young Women	416
Pitcher, Charles S.—Food Waste in Hospitals	491
Pneumonia Ward of American Red Cross Hospital, Liverpool, England	429
Porter, J. B.—Society for the Tuberculosis in the West of the United States (Ab.)	223
Porter, Charles A. and Carter, Herbert K.—Hospital Accounting	192, 173, 266, 371, 414
Power Plant and Heating Economies for Hospitals—Kimball	437
Practical Papers, Some (Ed.)	437
Presbyterian Hospital, Chicago	27
Presbyterian Hospital, Chicago, Economics in—Bacon	149
Prince, Ethel Anderson—Mental Hygiene and the War	196
Prison Labor, Employment of, on State Sanatorium Farm—Douglass	99
Psychopathic Hospital of the Laboratory of Social Hygiene, Brook Hills (Ab.)—Davis and Southard	499
Public Health, Increased Need for Care of (Ed.)	288
Public Health Nurses, Illinois Course for	49
Public Health Nursing and Social Work, South First School of Illinois	147

Q

Quarantine Stations at Didam, Sittard and Venloo (Ab.)	251
Queries and Answers	79, 150, 221, 420

R

Reconstruction Aides, Emergency Training for	480
Reconstruction from War and Industry, Discussion of, by American Association of Industrial Physicians and Surgeons	133
Reconstruction Hospital, First, Cornerstone of, Laid	148
Records, Hospital	
Efficiency System for the Medical Work of State Hospitals—Singer	260
Hospital Clinical Records, Method of Indexing—Byrne	86
Red Cross	
American, Nursing Program of—Delano	336
American, Work of, in Repairing Facial Defects—De Moncois	158
Canadian, Work Accomplished by, in 1917	49
Convalescent House at Walter Reed Hospital	47
Dietitian Service—Conley	407
Hospital, American, London	101
Hospital, Edward L. Trudeau Institution in France—White	247
Hospital, Pneumonia Ward of, Henry Hill, Liverpool, England	459
Institute for Crippled and Disabled Men—McMurtree	76, 145
Nurses, Enrolment of	305
Quick Action of, in Influenza Epidemic	392
Work, Excuses in, Need for (Ed.)	168
Work in India	168
Red Triangle Tuberculosis Farm Colony (Ab.)	222
Rehabilitation and Reconstruction Work of Canada—Kidner	393
Reid Memorial Hospital, Richmond, Ind.	284
Resolutions Presented by the Resolutions Committee of the American Hospital Association	328
Re-use Knitted Gauze Dressings	347
Robert W. Long Hospital, Indianapolis	285
Robinson, Margaret J.—Little Journeys to Places and People We Know	23, 103, 183, 281, 454
Ronzani, E.—The Care of Convalescents in the Ospedale Maggiore of Milan	152
Roosevelt Hospital, New York City	384
Rotating Service, Abolition of, During the War (Ed.)—Goldwater	115
Royal Navigation Company, Java, New Hospital for	302
Ruhl, Mary R.—Inexpensive and Simple Wardrobes	464
Rural Communities, Hospital Service in (Ed.)	464
Rutledge, J. A.—A Fraternal Institution for the Free Treatment of Tuberculosis	155

S

Sacred Heart Hospital, Fort Madison, Iowa	29
Saint Elizabeth's Hospital, Padua	153
St. Anthony, Newfoundland, Children's Home in	63
St. Anthony's Hospital, Carroll, Iowa—Robinson	108
St. Dunstan's Hostel for the Blind—McCallin	295
St. Joseph's Hospital, Carroll, Iowa	108
St. John's Guild, Floating Hospital of, Again at Work—Beckman	92
St. John's Hospital in Turin, Radiologic Division of	496
St. Joseph's Hospital, Ottumwa, Iowa	112
St. Luke's Hospital, San Francisco, Green Operating Room at—Sherman	97
St. Luke's Hospital, Chicago	27
Sanatorium, State, and the Labor Problem—Douglass	99
Sand, Rene—How America May Help Belgium after the War	256
Sandy, William C.—The Standardization of Hospitals for the Insane	6
Sargent Water Still	60
Saskatchewan, Schools, Medical Inspection for	301
School Medical Inspection in Saskatchewan	301
Seward, M.—How to Prescribe Rest and Exercise for Patients with Pulmonary Tuberculosis (Ab.)	152
Senior Pupils Nurses, Enrolment of, for Military Service (Ed.)	190
Shanahan, William T.—Institutions for the Care of Epileptics	364
Sharon Sanatorium, Children's Pavilion at, (Ab.)—Bowditch	222
Sheppard and Enoch Pratt Hospital, Towson, Baltimore	458
Sherrill, Harry—The Green Operating Room at St. Luke's Hospital, San Francisco	97
Shilt, Nell—The Conservation of Gauze	66
Ship Building, Welfare of Workers in	299
Shp, Hospital U. S. S. Mercy	213
Simpson, F. F.—A War Program of Vital Importance	278
Singer, H. Douglas—An Efficiency System for the Medical Work of State Hospitals	260
Small Hospitals—Affiliation for (Q. & A.)	150
Small Hospitals—	
Agatha Hospital, Clinton, Iowa	29
Ashland General Hospital, Ashland, Wis.—Dodd	264
Brookville General Hospital—Elder	165
Cottage Hospital, Creston, Iowa	112
Evangelical Deaconess Hospital, Marshalltown, Iowa	29
Jefferson County Hospital, Fairbury, Iowa	187
Kerrville Sanatorium Hospital, Kerrville, Texas	58
Sacred Heart Hospital, Fort Madison, Iowa	29
St. Anthony's Hospital, Carroll, Iowa—Robinson	108
St. Antonio Hospital, Carroll, Iowa	112
St. Joseph's Hospital, Ottumwa, Iowa	112
Tuberculosis Sanatorium Buildings, Small, Planning of—Burt	1
Smith-Sears Bill, Passage of	147
Smith, Winford H.—Some Aspects of the Progress of the Medical Department of the Army and Their Effect on Civil Hospitals	335

Social Service—	
and Hospital Efficiency—Warner.....	342
and the Influenza Epidemic (Ed.).....	390
Exchange of New York City.....	145
Made a Part of Nurses' Training at Louisville City Hospital.....	206
Social Work and Public Health Nursing, South's First School of.....	147
Social Workers, Hospital, American Association of.....	205
Social Workers, Hospital, First General Meeting of.....	343
Soldiers, Tuberculous, Rehabilitation of.....	46
Southard, E. E. and Davis, Katherine—Psychopathic Hospital of the Laboratory of Social Hygiene, Bedford Hills (Ab.).....	499
Spanish Influenza: See Influenza.....	
Spray Heater, Electric.....	422
Sputum Cup.....	153
St.: See under Saint.....	
Staff, Hospital, Resident, Self-Government for—Bacon.....	17
Staff Hospital, Written Versus Oral Instruction for (Q. & A.).....	221
Standardization of Hospitals—	
Epileptics, Institutions for Care of—Shanahan.....	364
France, Hospitals for.....	6
Standardization of Hospitals—Drew.....	56
State Hospitals—Bowen.....	81
Standardization of Staff and Hospital (Ed.).....	117
Stanford University Medical School, Adolescent Clinic of (Ab.).....	151
Gales.....	
State Hospitals, Efficiency System for the Medical Work of—Singer.....	260
State Hospitals, Standardization of—Bowen.....	81
State Institutions, Well Directed Offensive Against Political Jobbery (Ed.).....	288
State Sanatorium and the Labor Problem—Douglass.....	99
Sterilizing Machine, Large Portable, for Pershing's Troops in France.....	218
Stevens, Edward F.—Memorial Hall of Buffalo General Hospital.....	2
Stewart, Isabel M.—How the Colleges Can Help in the Training of Nurses.....	453
Stune, Cards Communiqué Clearing House, Influenza Relief Work of (Corr.)—Bradshaw.....	497
Sun Treatment: See Heliotherapy.....	
Surgical Dressing Squads, Life-Saving, in France—Crawford.....	178
Supervisors, Need of (Ed.).....	389
Supervisor, Night Graduate, A Necessity (Q. & A.).....	180
Suprapubic Drainage, Bottle for.....	225
Sutton, Mrs. Peggy Ann and Her Quilt (Corr.)—Farmer.....	200
Syphilis Clinic of Emory University, Atlanta, Georgia (Ab.)—Emery.....	152
T	
Tange, A.—The Mayo Clinics at Rochester, Minn., (Ab.).....	222
Technicians, Laboratory, needed (Ed.).....	32
Tent, Hospital, Six Hundred-Bed, Prepared in Twenty-five Days.....	195
Watson.....	
Tent Ward, Brooklyn Navy Yard Hospital.....	218
Test-Tube Boiler, Electric.....	154
Thermolite Heat and Light Infuser.....	153
Thompson, St. Clair—The Value and Limitation of Sanatorium Treatment for Tuberculosis (Ab.).....	224
Tilman, M. and Nemirovsky, M. A.—Radio-Chirurgical Aeroplane (Ab.).....	499
Toilet Seats, Sanitary (Q. & A.).....	420
Training Schools: See Nursing, Schools of.....	
Trains, Hospital, for Americans in France.....	218
Trolley, Hospital Ambulance, First.....	509
Tuberculosis, External, Hospital in Ibarritz for (Ab.).....	497
Tuberculosis, External, Treatment of by Heliotherapy.....	476
Tuberculosis Farm Colony, Red Triangle (Ab.).....	222
Tuberculosis Hospitals, Permanent, Building of, Approved.....	153
Tuberculosis, Pulmonary, Hospitalization of, Buenos Aires (Ab.)— Coni.....	222
Tuberculosis, Pulmonary, Rest and Exercise for (Ab.)—Seraud.....	152
Tuberculosis Sanatorium.....	223
Tuberculosis, Sanatorium for, in the West of the United States (Ab.) —Pons.....	223
Tuberculosis Sanatorium "Santa Maria," (Ab.)—Cabret.....	223
Barlow Sanatorium, New Four-Patient Cottage at—Klotz.....	373
Edward L. Trudeau Institution in France—White.....	247
Modern Woodmen of America Sanatorium, Woodmen, Col.—Rut- ledge.....	155
Tuberculosis Sanatoriums in High Altitudes and on the Plains (Ab.).....	497
Tuberculosis, Surgical, Heliotherapy and X-Ray in Treatment of.....	263
Tuberculosis, Value and Limitations for Treatment of (Ab.)—Thomp- son.....	494
Tuberculosis Work for Soldiers, Organization of, in France (Ab.).....	495
Tuberculosis Work in Argentina—Coni (Ab.).....	499
Tuberculous Soldiers, Care of (Ab.).....	496
Tuberculous Soldiers, Rehabilitation of.....	46
Tuley, Henry Enos—Some Problems of Hospital Management.....	169
Typhoid Patients, Hospitalizing of—Lebrede.....	224
U	
United States Public Health Service: See Public Health Service.....	
U. S.....	423
United States Shipping Board, Emergency Fleet Corporation, Wel- fare Work of.....	299
United War Work Campaign.....	23
Universal Service, Compulsory—Ministry of Health, A (Ed.).....	33
V	
V. A. D. in a French Hospital.....	212
Vancouver General Hospital, Military Annex of—MacEachern.....	257
Vancouver General Hospital, War Time Economics in—MacEachern.....	266
Van Der Bent, T. J.—War-Time Hospitals Present Ideal Conditions for Investigation.....	279
Vassar's Response to the Nation's Need for Nurses—Gray.....	270
Vassar Training Camp, Students of, Assigned to Duty.....	305
Vegetables and Fruits, Dehydrated.....	142
Veneral Disease Clinics—Davis.....	436, 481
Ventilator, Light-Proof, Dark-Room.....	500
"Verithin" X-Ray Cassette.....	80
Visitors and Visiting in Hospitals—Geffen.....	61
Vocational Instructors Needed in Military Hospitals.....	405
Vocational Therapy: See Occupational Therapy.....	
Volunteer Medical Service Corps (Ed.).....	287
Volunteer Medical Service Corps—Martin.....	275
W	
Walter Reed Hospital, Red Cross Convalescent House at.....	217
Wardrobe, Inexpensive and Serviceable—Ruhl.....	224
Wards, Hospital, Painting of (Q. & A.).....	420
War Industries Board and Hospital Supplies (Ed.).....	462
War: Its Hospital, Medical and Nursing Aspects.....	68, 148, 212, 416
War Service, Another Staff Member Called for (Ed.).....	290
War Service Committee Conference.....	35
War Service Committee of American Hospital Association, Report of.....	332
War-Time Hospitals, Possibilities of Investigation in—van der Bent.....	279
War-Time Institution Economics.....	66, 229
Warning Pad, Safety Electric.....	153
Warner, A. R.—Educational Work for Children at Lakeside Hospital.....	354
Evening Pay Clinic.....	143
Social Service and Hospital Efficiency.....	
Warner, Andrew R. and Davis, Michael M.—Dispensaries, Their Management and Development (Bk. Rev.).....	498
Who Should Be Dispensary Patients?.....	64
Warner, Mrs. Death of (Ed.).....	490
Warning to Hospitals Against Pretended Representatives of Modern Hospital.....	391
Washburn, Frederick P.—The Nurses' Home of the Hackensack Hospital.....	84
Water-Bath, Portable.....	225
Water Still, Inexpensive—Bacon.....	274
Water Still, Sargent.....	89
Weber, J. J. Health Work of Dennison Manufacturing Company.....	458
Weber, J. J. Work of.....	502
Welsh, Mabelle S.—Standard Curriculum for Schools of Nursing.....	39
West Suburban Hospital, Oak Park, Ill.....	27
Western Reserve University, Summer Course for Nurses at.....	486
Wheeler, Carlel A.—Summer Preparatory Course for Nurses at Western Reserve University.....	486
White, Wm. Charles—The Edward L. Trudeau Institution in France.....	247
Whitehill, G. E.—Organized Provision for the Care of the Sick in Massachusetts (Ab.).....	224
Wood, Derwent, Work of, in Repairing Facial Injuries.....	148
Woodward Gauge-Rolling and Folding Machine.....	421
Women Hospital Superintendents. Training and Rewards of (Ed.).....	387
Women's Hospital in the State of New York (Ab.)—Goffe.....	222
Workmen's Compensation, Health Insurance and Hospitals—Howell.....	414
Wounded of Biffi Pavilion, Instruction for (Ab.)—Medea.....	222
Wright, Howell—Report of the Legislative Committee, American Hospital Association Meeting, Atlantic City, New Jersey.....	329
X	
X-Ray Cassette, McIntosh, "Verithin".....	80
X-Ray Operator, Protective Glasses for.....	226
X-Rays and Heliotherapy in the Treatment of Surgical Tuberculosis.....	263
Y	
Y.W.C.A., War Work of—Nissley.....	416
Youngstown Hospital, Youngstown, Ohio.....	29



THE MODERN HOSPITAL

*A Monthly Journal Devoted to the Building, Equipment, and
Administration of Hospitals, Sanatoriums, and Allied Institutions,
and to their Medical, Surgical, and Nursing Services*

Vol. XI

July, 1918

No. 1

THE PLANNING OF SMALL TUBERCULOSIS SANATORIUM BUILDINGS

**Wise Economy a Duty in Employment of Public Funds—Attractiveness, Durability,
and Convenience Attainable at Low Cost—Plans Drawn for Use of New York
State Department of Health**

BY JAMES D. BURT, ARCHITECT, NEW YORK.

WRITTEN across the top of the New York State Department of Health letter-heads is the slogan: "Public Health Is Purchasable. Within Natural Limitations Any Community Can Determine Its Own Death Rate."

This claim, startling and ambitious as it may appear, has proved true by demonstration in the results of the various activities of progressive health departments in our own as well as in foreign countries; it would appear that the statement is not a boast, but a well-settled and generally admitted fact.

"How much is the cost?" is a natural question to ask when a statement is made that a thing can be purchased. If the cost of a thing is exorbitant and beyond the ability of the would-be purchaser to pay, then no purchase is made and the dangerous condition is not remedied: *Public health must be made purchasable at a reasonable price.*

What are the things which call for the outlay of money in connection with this purchase of health? Doubtless professional and expert advice and direction are a necessary and preliminary part of the expense of public health. We are concerned, however, in this article, only with that part of the outlay which applies to the building and equipment for the treatment of cases of tuberculosis.

Because the treatment of tuberculosis is so largely hygienic—the living of a normal life under favorable conditions—a large part of the first cost is represented by the necessary buildings and equipment; it is in the economy, or the lack of it,

as applied to this part of the outlay that determines whether or not health may be purchased at a reasonable cost.

In these days of multiplied social activities, when the community and the state are assuming control of and responsibility for the prevention and treatment of communicable diseases, in addition to various other social interests, it is becoming more and more urgent that money raised for these purposes shall be wisely used and made to perform its work as efficiently as possible in justice to those who willingly or unwillingly are taxed to meet the financial burden thereby imposed.

Economy and good judgment have not always characterized the expenditure of public funds, even when so important a matter as the public health is at stake; we still have with us a considerable number of those who consider a public enterprise as an occasion of very liberal expenditure of money, if not an opportunity for actual plunder. One does not have to go far to find glaring examples of buildings and equipment which are monuments of wastefulness and inefficiency.

There is not only no excuse for this, but, in view of the many sufferers who ought to be cared for in sanatoriums, but who cannot be received because of lack of room or the high cost of treatment, it becomes a crime and no building committee or board of supervisors is justified in spending more than a reasonable amount for their buildings and equipment—such an amount as, when placed in the hands of a trustworthy and



Fig. 1. Tuberculosis sanatorium for fifty patients. Typical design for the Department of Health of the State of New York. Herman M. Biggs, M.D., commissioner; James D. Burt, architect.

competent architect, will produce structures that are at once attractive, economical, durable, and convenient.

Applying this to the specific matter of the building or buildings for a small tuberculosis sanatorium, we shall endeavor to illustrate a few simple and commonplace principles which experience has taught us to observe if the foregoing four requisites are to be secured.

The matter of appearance and general attractiveness should receive at least as much attention as the design of a private residence of equal cost. The institution is to be the home, for the period of their treatment, of many who come to it under peculiarly adverse circumstances, and it is left to the environment, both physical and social, as well as to fresh air, sunshine, and good care, to establish and to maintain the feeling on the patient's part that he has come to the place where health is to come again, and where for the time, to as great extent as possible, all care and anxiety are to be dissipated.

Nor is it necessary to be extravagant in order to make a building attractive. Usually, and particularly in such a building, simplicity is the keynote of attractiveness; plenty of sunlight and air with ample opportunity for yet more air, with protection from cold winds; quiet, cheerful colors; a pleasant outlook; opportunity for privacy, so far as may be, with all physical needs easily provided for—these are all a part of the general attractiveness which appeals to the average patient.

As for economy of construction, of course there is an economy which might better be called parsimony, for no method of construction which has only low initial cost to recommend it can be justly called economical if the usefulness of the building

will be of short duration and it must soon be repaired or replaced. The matter of strength and durability should be more accented in public or semipublic institutions than in private buildings, for the reason that they are given harder usage in spite of the greatest watchfulness. There will always be a certain number of persons who will never catch the spirit of personal responsibility in the use of public property.

The matter of wise, economical construction and equipment may well be a matter for cooperation on the part of the architect and the hospital board.

Convenience in layout is a very important matter, on the score both of general utility and satisfaction and of the cost of administration. A building correctly planned and equipped will save the services of one or more persons over a building that is poorly planned, thus avoiding a perpetual loss and a constant irritation.

The example here illustrated is selected from a number of model or typical plans designed for the New York State Department of Health, and intended as a guide in the designing and construction of the various county tuberculosis hospitals which, under the recently enacted law, must be erected in all counties with a population of 35,000 or more which are not already provided with adequate accommodations for tuberculous patients. The present commissioner of the department, Dr. Hermann M. Biggs, an acknowledged international authority on all matters relating to the study and treatment of tuberculosis, from the beginning of his activities regarding public health in general and tuberculosis in particular, has been very pronounced in his insistence on the dissemination of all that has been learned

relating to the causes and treatment of this dread disease. The best advice and suggestions have been available for the asking; if there is any person of understanding of any nationality in this

These drawings are a part of the liberal propaganda in this war against tuberculosis; the maker of them does not pretend that they are a perfect solution of the problem of sanatorium construc-

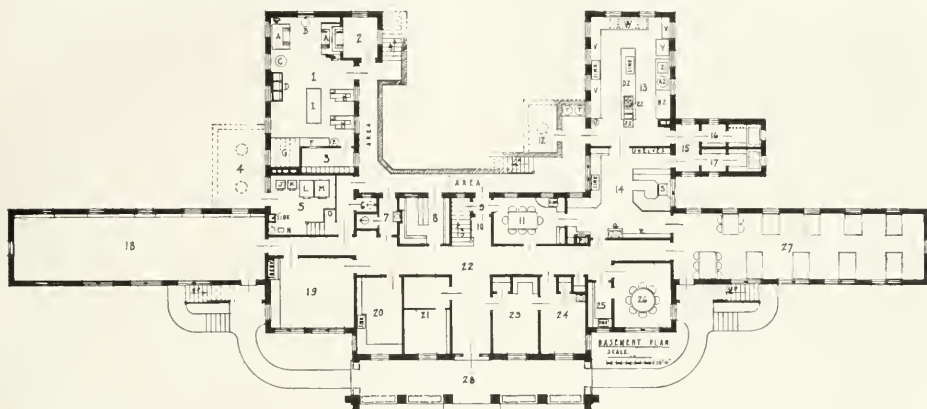


Fig. 2. Basement plan of the fifty-bed tuberculosis hospital shown in Fig. 1. In this and the following plans the scale shown in the lower part of the drawing represents 10 feet.

- | | | | | |
|----------------------|----------------------------|------------------------------|-----------------------------|----------------------------|
| A. Washing machines. | M. High-pressure boiler. | Y. Cabinet oven. | 5. Boiler room. | 17. Milk, butter, eggs. |
| B. Soap tank. | N. Vacuum cleaner machine. | Z. Vegetable cooker. | 6. Toilet. | 18. Recreation room. |
| C. Extractor. | O. Sputum depository. | AZ. Stock pot. | 7. Women's toilet. | 19. Sewing and mending. |
| D. Wash trays. | P. Dumbwaiter. | EZ. Range. | 8. Store room. | 20. Medical laboratory. |
| E. Starch kettle. | Q. Coffee and tea urns. | DZ. Cook's table. | 9. Vestibule. | 21. Business office. |
| F. Table. | R. Dish shelves. | EZ. Steam table dish warmer. | 10. Stair hall. | 22. General hall. |
| G. Dryer. | S. Dish washer. | FZ. Meat block. | 11. Help's dining room. | 23. Physicians' office. |
| H. Ironers. | T. Garbage cans. | 1. Laundry. | 12. Kitchen coal. | 24. Examination room. |
| I. Folding table. | U. Vegetable peeler. | 2. Receiving room. | 13. Kitchen and bakery. | 25. Staff pantry. |
| J. Incinerator. | V. Vegetable preparation. | 3. Clean linen room. | 14. Serving pantry. | 26. Staff dining room. |
| K. Hot water heater. | W. Baker's table and bins. | 4. Coal | 15. Refrigerator vestibule. | 27. Patients' dining room. |
| L. Heating boiler. | X. Baker's proofer. | | 16. Meats, fish. | 28. Entrance porch. |

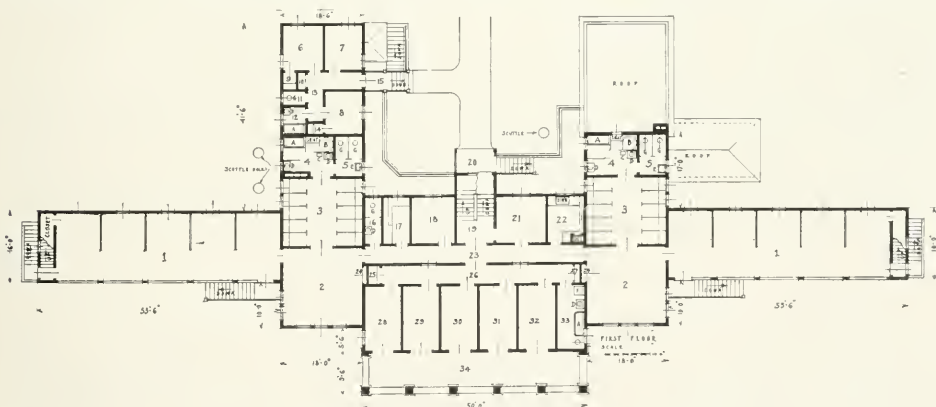


Fig. 3. First floor plan of the fifty-bed tuberculosis hospital shown previously.

- | | | | | |
|----------------------------|---------------------------|-------------------------|--------------------------------|-------------------------|
| 1. Open wards. | 16. Attendants' toilet. | 22. Diet kitchen. | 28-33. Bed patients' quarters. | E. Slop sinks. |
| 2. Sitting rooms. | 17. Supplies, linen, etc. | 23. General corridor. | 34. Bed patients' porch. | F. Utility sink hopper. |
| 3. Dressing rooms. | 18. Nurses' room. | 24. Bed shelves. | A. Bath tubs. | G. Water closets. |
| 4. Lavatories. | 19. Stair hall. | 25. Linen closet. | B. Showers. | H. Dumbwaiter. |
| 5. Toilets. | 20. Rear porch. | 26. Bed patients' hall. | C. Dental lavatory. | I. Shelves. |
| 6-15. Men help's quarters. | 21. Unassigned. | 27. Closet. | D. Wash basins. | |

state who does not to some extent appreciate the malignant nature of this disease and the steps to be taken towards a cure, he has deliberately shut his eyes and his ears so that he could not see and hear the evidence and the testimony regarding it.

tion, but they do contain some principles which should be included in the layout of every tuberculosis hospital, whether large or small.

The controlling idea in these plans is to provide for fifty cases of incipient tuberculosis with the

usual proportion of bed patients, together with the staff and all helpers needed in the institution, with as little outlay as possible under the circumstances and without the sacrifice of any desirable feature or detail.

It is assumed that the site is on a hillside sloping toward the south, protected from the north and west winds by the rise of the hill behind. This

1. Entrance halls and corridor.
2. Business office—stenographer, mail, etc.
3. Physicians' office—patients, records, etc.
4. Examination room—nose, throat, etc.
5. Medical and laboratory room.
6. Reception room or general waiting room.
7. Linen closet.
8. Broom closet.
9. Staff toilet for men.

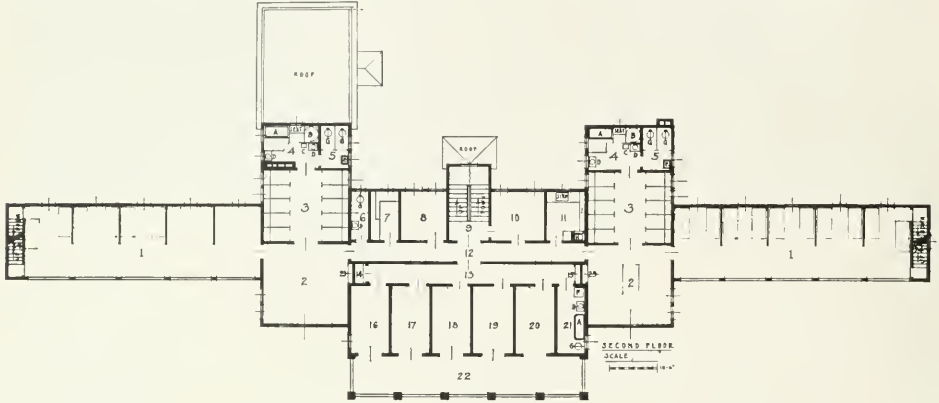


Fig. 4. Second floor of the same fifty-bed tuberculosis hospital.

- | | | | | |
|-------------------------|--------------------------|--------------------------------|----------------------|------------------|
| 1. Open sleeping wards. | 7. Supplies, linen, etc. | 13. Bed patients' hall. | 24. Fire escape. | F. Utility sink. |
| 2. Sitting rooms. | 8. Nurses' room. | 14. Linen closet. | A. Bath tubs. | G. Water closet. |
| 3. Dressing rooms. | 9. Stair hall. | 15. Closet. | B. Showers. | H. Dumbwaiter. |
| 4. Lavatory. | 10. Help's sitting room. | 16-21. Bed patients' quarters. | C. Dental lavatory. | I. Shelves. |
| 5. Toilets. | 11. Diet kitchen. | 22. Bed patients' porch. | D. Wash basin. | |
| 6. Attendants' toilet. | 12. General corridor. | 23. Book shelves. | E. Slop sink hopper. | |

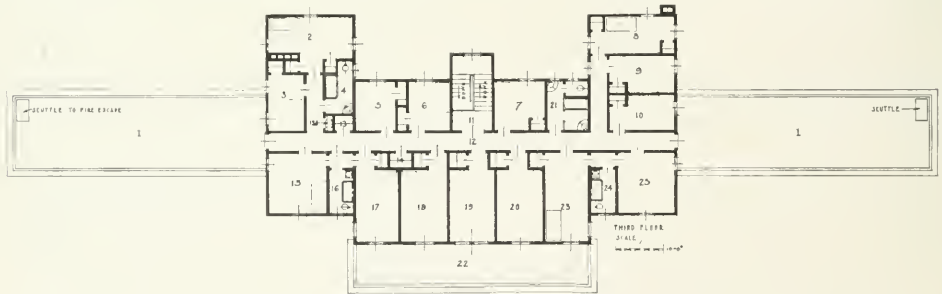


Fig. 5. Third floor of the tuberculosis sanatorium.

- | | | | | |
|----------------------------|--------------------|----------------------------|-------------------|---------------------------|
| 1. Roofs. | 7. Servants' room. | 12. General corridor. | 16. Bath room. | 21. Nurses' room, toilet. |
| 2. Servants' room. | 8. Servants' room. | 13. Servants' linen. | 17. Nurses' room. | 22. Roof over porch. |
| 3. Servants' room. | 9. Servants' room. | 13A. Slop sink closet. | 18. Nurses' room. | 23. Physicians' quarters. |
| 4. Servants' room, toilet. | 10. Stenographer. | 14. Nurses' linen closet. | 19. Nurses' room. | 24. Physicians' quarters. |
| 5. Servants' room. | 11. Stair hall. | 15. Head nurse and matron. | 20. Nurses' room. | 25. Physicians' quarters. |
| 6. Servants' room. | | | | |

allows the placing of the main entrance in the basement about on the level of the ground in front, giving full windows on the south, avoiding a number of outside steps to a first-floor front porch, and leaving the entire front porch of the first and second floors available for patients.

The rooms and accommodations actually needed, allowing for slight modifications one way or the other, are as follows:

10. Staff toilet for women.
11. Patients' dining room (15 square feet for each).
12. Serving pantry.
13. Kitchen, bakery, and preparation room.
14. Refrigerating room.
15. General storeroom, vegetable cellar, etc.
16. Staff dining room, accommodations for eight persons.
17. Staff pantry.
18. Help's dining room—sink, dish cupboard, etc. Accommodations for twelve persons.
19. Help's toilet for men.

20. Help's toilet for women.
21. Heating plant and coal storage.
22. Sputum destroyer—incinerator.
23. Laundry.
24. Workroom—mending, repairing, sewing, etc.
25. Recreation room and library for patients.
26. Mortuary.
27. Trunk room—suit cases.
28. Living room, bath, bedroom for physicians.
29. Living room, bath, bedroom for matron and head nurse.
30. Nurses' bedrooms for six nurses.
31. Stenographer's and bookkeeper's bedroom.
32. Sitting room for nurses.
33. Baths and toilets for nurses.
34. Servants' (women) bedrooms for nine women.
35. Sitting room for servants.
36. Baths and toilets for servants.
37. Men workers' bedroom for three men.
38. Baths and toilets for men workers.
39. Open wards—stalls for each two patients.
40. Living room for patients, 20 square feet to each patient.
41. Dressing rooms 3 by 5 feet, one for each patient.
42. Baths—toilets for patients.
43. Blanket warmer, a fixture 2 by 4 by 6 feet high, coils under shelves.
44. Bed patients' quarters (20 percent and above of total number of patients).
45. Baths and toilets for bed patients.
46. Separate corridor or hall for bed patients.
47. Room for nurse in charge.
48. Diet kitchen.
49. Supply room—linen, etc.
50. Vacuum cleaner system by motor in basement.

As to the materials to be used in the erection of this building, in order to secure the desideratum of economy and durability, this is largely a matter of local availability and cheapness. Where good lumber is to be had in quantity, the argument would be in favor of a frame building modified to make it as safe as possible from fire risk, whereas in a locality where stone and sand may be obtained cheaply, the type of construction would naturally be of masonry or concrete. This matter may safely be left in the hands of a judicious architect. The cost of the building is naturally governed by the materials used and the expense of assembling them; local rates of wages; these fluctuate greatly, especially in these war times.

The principal reasons for including under one roof the various activities of an entire sanatorium are the economy of first cost and ease of administration. There are good arguments in favor of building a group of three or four buildings for even so small a number as fifty patients. It is the endeavor to illustrate here the *cheapest* solution for the problem compatible with satisfactory provision for the treatment of tuberculous patients, leaving to individual and specific cases the expansion of the principles thus set forth.

The details of construction should be such as have been proved best in hospital building. There

are many minor points in this connection which become important when a plant is in operation, and which may be overlooked by an architect who has not had some experience in hospital construction; the so-called major matters are not so apt to be neglected.

It is unnecessary to explain in detail by text the points to be considered; they are apparent by reference to the accompanying plans. Exception may be taken to the number of persons constituting the staff and corps of helpers for whom quarters are provided. Those who are unfamiliar with the operation of such a sanatorium have raised the question. There may be localities where especially favorable conditions enable the institution to obtain certain unskilled help in the immediate neighborhood by the day, but the number here provided for, or closely approximating it, has been proved by extensive experience to be necessary if the institution is to be well served.

Finally, although advocating economy, we strongly advise against that false economy which tends to count a thing cheap because its first cost is low; perhaps in no other kind of building is this so great a fallacy. On the other hand, a thing is not good because it is high in price. There is at every step abundant opportunity for the exercise of judgment and discrimination in the outlay of money for professional services, and labor, for materials, and for equipment.

If all our hospitals and sanatoriums are erected with judicious economy as a guiding principle, it will aid materially in stamping out or in bringing under control diseases against which progressive thinking and public-spirited men and women have long labored with a good measure of success, but whose unselfish efforts will be multiplied when the money available is made to do full duty in providing for a greater number without additional outlay.

To Sift Out Feeble-Minded Inmates of New York Institutions

Governor Whitman of New York has signed the Sage-Machold bill adding to the duties of the Hospital Development Commission, which was created by the last legislature to formulate a systematic plan for more adequate facilities for the insane and feeble-minded. The bill authorizes the commission to make recommendations for a reclassification of the inmates of state institutions, except the prisons and the hospitals for the insane, with a view to the segregation of the feeble-minded. This will enable the development commission to make inquiry as to whether the inmates of the various state institutions, a large percentage of whom are feeble-minded, should be reclassified and one or more of the institutions be set aside for defective delinquents. The need of accommodations for the criminally inclined among the feeble-minded is one of the most pressing phases of the problem.—S. C. A. A. News.

THE STANDARDIZATION OF HOSPITALS FOR THE INSANE*

Advantages of State Over Private and County Institutions—Importance of Fire Protection—Toilet Arrangements, Bathing, Heating, and Lighting—Governmental and Administrative Conditions

BY WILLIAM C. SANDY, M.D., ASSISTANT SUPERINTENDENT CONNECTICUT HOSPITAL FOR THE INSANE, MIDDLETOWN, CONNECTICUT.

THERE is probably no special class of hospitals in greater need of standardization than that devoted to the care and treatment of the insane. Vast sums are annually appropriated for the maintenance of the public institutions for the insane. From the standpoint of the taxpayer, every effort must be made to establish methods of economical care. It is of vital importance to the public welfare, however, that such equipment and facilities be furnished as will promote every possible chance for restoration, and that provision be made for prophylactic measures. For it should be generally recognized that the likelihood of recovery may be increased, and recovery itself hastened, by the application of proper methods of treatment, and that in prophylaxis lies the principal hope for the future in combating the ever-increasing problem of the insane.

In general, there are three great classes of institutions for mental diseases—the private, the county, and the state. The private hospitals, usually called sanatoriums, occupy a peculiar and special position, often providing the exclusive and individual care which appeals to those who can afford the high rates commonly demanded. There are many well-equipped and admirably conducted private hospitals where the most modern forms of treatment and the best results may be obtained. On the other hand, unfortunately, there are privately conducted institutions, hospitals in name only, with exorbitant rates and bare custodial care, the standard being scarcely above that of a first-class almshouse.

The county hospitals, aside from the few large institutions which resemble in management the state hospitals, are generally unsatisfactory. This is, for the most part, due to a close affiliation with almshouses and to political administration. The limitations of this paper will not admit an adequate discussion of these institutions with their meager equipment, lack of treatment, and untrained medical staffs, all of which should be regarded as relics of the past.

The state hospitals, usually free from serious political entanglements, with the resources of the state behind them, are provided with larger staffs

of trained physicians, better equipment, and more scientific methods. It is the purpose of this paper to consider the state hospitals and to outline briefly what may be regarded as desirable and possibly ideal, according to the present knowledge in respect to equipment, methods, and the like.

In discussing the question of standardization of state hospitals for the insane, one should bear in mind the objects of such hospitals. While in some sections of the country it is still customary to use the term "asylum" and many of the institutions are little better than the old custodial type, the best modern hospitals for the insane have far higher ideals and a broader scope. It should be the aim of the hospital to restore, as soon as possible, the recoverable; to prevent deterioration and to endeavor to reeducate the so-called chronic; to treat successfully the physically ill; to guard against injury or accident, such as suicide; to care for and make comfortable the excited, the feeble, and the aged; to hold those dangerous to themselves or to the public; to make such full examinations and keep such complete records that the work of the hospital will have present and future scientific value; and, finally, through outside agencies, to be an active force for mental hygiene. It is needless to say that all of this is to be done in as efficient and economical a way as possible.

Very little will be said as to the proper size of institutions. This is purely a matter of theory, the actual size of hospitals being largely determined by the exigencies of the situation. Economy and the increasing number of patients make necessary, quite generally, large institutions. While it is undoubtedly true that the average executive will be more successful with hospitals of two thousand patients or less, institutions of over five thousand will be found to be efficiently operated, depending upon the capability of the administrator and his assistants.

In selecting the site for a hospital, preference should be given to a location somewhat removed from the large centers of population, in order that sufficient ground for exercise, with desirable privacy, may be obtained for the patients, and also ground for a farm and garden large enough to supply the necessary products for maintenance. Some consideration also should be given to the

*This paper is the third in a series, by various authors, on the standards of the various classes of special hospitals. The first, "Standards for a Children's Hospital," by Stafford McLean, appeared in the May issue; the second, "The Standards of Hospital Education for Internists," by J. M. Baldy, was published in June.

natural beauties and the hygienic qualities of the site, and it is, of course, essential that it be well drained and supplied with an abundance of pure water. While avoiding large cities, it is desirable to have the hospital accessible to a small town or city in order to insure the necessary diversion for employees, the obtaining of whom, at the present time, is an increasingly difficult proposition. The hospital should be connected with both steam and electric railways on account of freight facilities and the convenience of visitors and employees.

In the early days of state hospital construction, the architectural tendencies were towards massive single buildings of monastery or prison-like appearance, several stories in height and with rather numerous but needless ornate features, especially in the administration portions. While attractive appearance should not be disregarded, the substantial and fireproof qualities are far more essential. The present tendency is more towards detached groups of buildings. The so-called cottage plan is probably the ideal, but is not practicable except on a large scale, that is, single buildings accommodating several hundred patients. Farm colonies, utilizing more cheaply constructed and temporary buildings, have demonstrated their usefulness for the chronic, quiet workers. In any case, buildings of more than two stories are seldom, if ever, desirable.

Too much attention cannot be paid to fire protection. The above-mentioned old type of single, large building, often a veritable firetrap, should be remodeled so as to be divided up into several units separated by fire walls and automatic fire doors. Outside covered fire escapes of approved type and inside fireproof stairways should provide sufficient exits from every floor. These precautions are indispensable, as are also outside hydrants, standpipes, and hose on every floor connected with a water system of sufficient amount and pressure supplemented by a fire pump for emergency added pressure. All exit doors should open outwards.

The interior plans of the buildings, an adequate discussion of which would necessitate a volume, will be covered only in a general way. An excellent type of ward is one provided with a day room connected with a fireproof porch, a large dormitory for sleeping purposes, and a water section with sufficient toilet and bathing facilities. Necessary adjuncts are adequate clothes rooms, lockers, and the like. The dormitory for sleeping purposes, simplifying the night watch service, is applicable in the case of most varieties of mental disease, but a few single rooms are often desir-

able for certain violent, dangerous, or paranoid individuals.

There should be a sufficient number of wards or units to facilitate proper classification of patients based largely upon their demeanor and physical condition. New patients and those who may be convalescent, feeble, or of the quiet and tranquil type, should not be subjected to the annoyance and undesirable association with the violent, destructive, noisy, and untidy. An idea as to the requirements may be obtained from the following estimated percentage of the different classes. The acute or reception service may be represented by 5 percent; the hospital or physically ill, 2 percent; the chronic, quiet, and clean, 28 percent; the disturbed and violent, 16 percent; the feeble, aged, and infirm, 20 percent; working, 17 percent; tuberculous, 5 percent; epileptic, 5 percent; convalescent, 2 percent. A desirable feature, if possible, is a separate building for the acute, reception, or as it is sometimes called, psychopathic department, especially well equipped for treatment, including an operating room. The tuberculous also are preferably cared for in separate and specially designed buildings.

In the matter of toilet arrangements, one seat to ten, or at least fifteen patients, with twice the number of wash basins may be considered a minimum requirement. The hoppers should be of the type which flush automatically when used. All hot-water faucets should be provided with safety devices to prevent patients from scalding themselves. Probably the simplest and safest way is to have the hot water turned off and on by means of a key with which the nurses and attendants only are provided; although theoretically the plan sometimes adopted of having a thermostatic attachment to the hot-water system is good.

The question of proper bathing facilities is one only too frequently neglected. No longer should bathtubs be deemed satisfactory equipment. It is a regrettable but actual fact that, where tubs are used as the sole method of bathing, many patients may be bathed by careless or ignorant attendants without changing the water. The only safe and sanitary method is by showers, each patient then being assured a clean bath, and a large number being easily bathed in a short time. TubS are required for special cases, such as some of the infirm, but shower baths are practicable for the majority of patients, both men and women.

Heating by direct radiation is probably, at the present time, the most satisfactory method. All radiators and hot pipes should be covered or placed out of reach of patients who otherwise

might easily be burned. The heating system should be combined with some method of automatic forced ventilation.

Lighting should be by electricity with properly protected wiring, the only special consideration being that the turning on and off of the lights should be under the control of the nurses and attendants, by means of some key device.

It will suffice merely to mention certain other indispensable departments and facilities which for the most part do not acquire any new characteristics by reason of the special nature of the institution. Every hospital should have a proper method of sewage disposal. Necessary departments are the kitchen, bakery, dairy, store, laundry, the shop, e. g. carpenter, painting and mechanical, the cold storage and ice plant, the central lighting, heat, and power plant.

Some thought should be given to the proper housing of resident officers and employees. Comfortable quarters should be furnished, the hospital service being for many a lifetime career. There should be an employees' home with provisions for single and married attendants and nurses.

While the physical conditions of hospitals for the insane present many peculiar problems, such as have been briefly outlined, the governmental and administrative conditions are even more special in type and importance. Good work may very likely be accomplished by capable men even though handicapped by poor equipment, but surely proper methods of government and administration are indispensable.

Most state hospitals are under the general supervision of an unpaid board of managers or trustees appointed by the governor. That this board should be nonpartisan, free from petty political entanglements, fairly secure in office, and not subject to the liability of sudden removal, in the event of change of administration, should be self-evident. This may be accomplished by the provision that the board shall be continuous, the term of office of only a part expiring each year. Among the various duties of the board should be the close inspection of the finances of the hospital—this final control of the expenditures, if conscientiously carried out, assuring the safeguarding of the public's interests.

The selection and appointment of the resident superintendent should be left largely in the hands of the board of trustees, who alone should have the power of removal, giving the executive officer the security in office essential for effective work. The primary aim of the hospital being medical, there can be no question that the chief executive

officer should be a physician, one who has gained his experience in psychiatry by actual residence in hospitals for the insane, and who has demonstrated the necessary executive ability. Many of the difficulties preventing successful administration are due to frequent changes and the inexperience of political appointees. Divided and uncertain authority will merely serve to hinder the progress which is otherwise to be expected from the activities of a capable executive.

The assistant officers and heads of departments should be appointed by the board of trustees upon the recommendation of the superintendent and should be entirely under his direction.

Generally speaking, a desirable proportion of physicians to patients is about one to two hundred. The different services require a varying number, the acute or reception, for instance, require more than the chronic. In the larger hospitals there should be an assistant superintendent and a clinical director, the duties of the former being to relieve the superintendent of certain routine matters, such as the help problem, those of the latter being to supervise and correlate the medical work. In the smaller hospitals these two positions may very easily be combined.

There should be enough resident experienced assistant physicians to take charge of the various services. A requisite number of resident junior assistants and interns are required to assure the proper attention to routine details. The interns may be only temporary officers serving largely for the experience. The other members of the staff, however, should, as far as possible, be registered physicians interested in the study of psychiatry as a career. Every hospital for the insane should have at least one woman physician on the staff, chief among whose duties should be to make those special examinations and treatments so essential to the comfort and welfare of the women patients.

A successful administration of the hospital will depend largely upon the qualifications of the heads of the departments. Executive ability and expertness in the special field coupled with loyalty and cooperation are essentials to be looked for. A business manager, purchasing agent, or steward is required, one who is able to install modern business methods, and who is qualified as a judge and buyer of supplies. Other important positions are storekeeper, farmer, engineer, head carpenter, laundryman, and chef, all of which come under the immediate supervision of the business manager. There should be a matron whose duty is the general supervision of the housekeeping and the help therein engaged. More detailed discus-

sion of these and similar positions is not necessary, as there are no very unusual conditions liable to be met with in these departments, owing to the special nature of the hospital.

The importance of having a sufficient number of reliable nurses and attendants is self-evident. It is in this department, however, that one of the greatest difficulties is encountered, it being almost impossible to secure enough help (in numbers) without much regard to the quality. This has become especially true since the beginning of the war because of the high wages offered by munition and other industries. Many hospitals have been brought to the necessity of hiring practically all applicants without regard to grade and even then being twenty-five percent or more short-handed. In view of the scarcity of applicants, it is almost useless to state that there should be at least one nurse or attendant to ten patients, a proportion seldom possible at this time. Especially on the reception and infirmary wards for men, women nurses should be employed. Where it is possible to secure enough competent women nurses, they should be placed in charge of other male wards, with resultant improvement in the quality of nursing and housekeeping, and less liability of ill-treatment of patients.

An adequate force of attendants and nurses should be assigned to the night service, the minimum requirements being, generally speaking, one nurse or attendant to forty patients. In any case, there should be a sufficient number of employees to permit the doors of a majority of the patients' rooms to be unlocked at night. This expedient is exceedingly important from the standpoint of fire protection alone, as is also the holding of regular fire drills of both employees and patients, the former being taught the use of fire-fighting apparatus, including hose and extinguishers, which should be plentifully supplied throughout the hospital, and the quickest way of getting the patients out of the buildings. In connection with this, and for additional fire protection, it is well to have two fire companies composed of outside employees and provided with hose-carts, chemical apparatus, ladders, life-nets, and so forth, and which hold regular, practical drills. The existence of two companies, each with a chief, will result in a wholesome rivalry and increased efficiency. Besides the inside night service, there should be enough outside watchmen to insure the required order and safeguarding of the buildings and grounds. As a check upon the night service, a modern watchmen's clock system should be installed, or both the inside and outside night employees may be correlated by means of

a system of ringing in to a central office, such as is found in a first-class police department. The latter plan combines the desirable features of both a watchmen's clock and a standard fire-alarm system at probably no greater expense.

In immediate charge of the attendants and nurses of each service should be a day and a night supervisor who are the physicians' representatives in respect to discipline, order, and direction.

The training school for nurses should be an important adjunct to every hospital for the insane. While most of those in immediate charge of the patients will be of the attendant class, perhaps with considerable practical but with little theoretical knowledge as to proper methods, the presence of a good training school will mean that there will be a certain number of the more intelligent men and women undergoing instruction which cannot fail to elevate the standards of care and treatment. The quality of the instruction, of at least two but preferably three years' duration, should be such that with an additional post-graduate course in a general hospital, the graduate of the training school may obtain state registration. At the head of the training school should be a competent superintendent of nurses, a graduate nurse of recognized standing. The lectures should be given by the members of the resident medical staff. The ordinary attendants should also receive instruction in the more practical and necessary branches in order that they may have a proper conception of their duties.

While perhaps of less relative importance than in the case of general hospitals, a well-stocked pharmacy is required, presided over by a registered pharmacist. Much of the latter's time will be taken up with prescription compounding, as few drugs will be kept on the wards.

The efficiency of the medical work will depend to a considerable degree upon the routine method of examination and treatment prescribed for the medical staff. Upon admission every patient should be placed in bed in an observation ward for a week or ten days, during which time a thorough mental and physical examination should be made. In the physical examination nothing should be neglected. The ordinary laboratory procedures, such as urinalysis, should be supplemented by such special examinations as that of blood, sputum, gastric contents, feces, and so forth, as may be indicated. A Wassermann blood test should be done in each case with spinal fluid examination where indicated. A detailed mental examination, modeled after that recommended some years ago by Adolf Meyer, should be made. The results of the mental and physical examina-

tion are then to be typewritten in accordance with a regulation form; the latter being necessary in order that every item of importance in the patient's condition may be covered, for his own welfare and so that the statistical and other records may be made of the greatest possible future value. This, of course, presupposes that adequate clerical and stenographic assistance shall be available.

At staff meetings held daily, or frequently enough for the accomplishment of the work, and presided over by a clinical director or other competent officer, each case history is to be read and the patient presented in person in order that the benefit of a full consultation as to diagnosis, treatment, and other matters of importance may be assured all patients admitted.

Space will not allow a detailed discussion of certain other necessary facilities. To secure thorough treatment for all, there should be proper dietetic arrangements, surgical equipment for any operation, a consulting staff of surgeons, electrical apparatus for diagnosis and treatment, a resident dentist with the required equipment, and some provision for ophthalmological and other special examinations when required.

No hospital for the insane is adequately prepared without provisions for the application of hydrotherapy. By hydrotherapy is meant treatment by means of the continuous bath, the various forms of wet-pack and special baths, such as the needle, rain, shower, the different douches and the like. The lack of hydrotherapeutic facilities (associated also with an insufficient number of attendants, too few wards for the proper separation of the disturbed, and faulty methods of treatment) account to a great degree for the practice in some hospitals of restraint and seclusion, which no longer are countenanced in the best modern hospitals except in extreme cases.

Occupation, when properly applied as a therapeutic agent in the treatment of the insane, not only retards mental deterioration, in many cases, but also frequently hastens recovery and serves to prepare the patient for a return to his normal environment. One or more full-time instructors are required, and the various forms of diversional occupation, such as raffia and reed basketry, rug, brush and broom-making, knitting, crocheting, tatting, embroidery, and the like, cement-work, chair caning, and so forth, should be made available. Of great value, in the same way, and of considerable economic importance are the opportunities for farm and garden work available to the patients. Besides the foregoing, much of the clothing, the shoes, the mattresses, and some of

the furniture may be made by patients under supervision.

There should be a school with a teacher competent to apply graded reeducational methods helpful in certain classes of patients.

Recreation also is effective as a means of arousing the interest and of combating the tendency to dementia. No community is doing justice to the insane in its care without providing forms of amusement in the shape of dances, moving pictures, baseball, and other kinds of games and entertainments. There should be an athletic field and also a fireproof assembly hall large enough to accommodate a fair proportion of the patient population. Religious services should be held regularly, presided over by clergymen of the various denominations.

Some reference has already been made to laboratory requirements. Every hospital should be prepared to carry on, as routine measures, the various tests so necessary as aids in diagnosis, not only for mental disease but also for ordinary physical ailments. The medical staff should be on the alert to secure permission for post-mortem examinations in the interest of science and the welfare of humanity. Facilities should be provided for the proper study of the material obtained. The laboratory ought to be in charge of a trained pathologist with adequate assistants to enable him to do research work.

One frequently hears of the "ever-widening influence of psychiatry," as a consequence of which institutions for the insane and the officers connected with them can no longer restrict their activities to a small sphere of the "asylum," as formerly designated. The facilities for advice, observation, and treatment must be extended by the establishment of out-patient departments and psychiatric wards in general hospitals in the large centers of population. In this way, as is shown by actual experience, thousands of persons may be reached and benefited in the early and borderline stages of psychosis development and restored to mental health in a short time, avoiding what is now so often wrongfully considered the stigma of commitment in a hospital for the insane. The frequently unwieldy, slow, and public methods of commitment procedures, often treating a prospective patient as a criminal, incarcerating him in a jail, escorting him to the hospital, it may be, handcuffed and in the custody of an officer, must be replaced, so far as possible without endangering his constitutional rights, by prompt and expert examination, care of trained attendants, and quick and unobtrusive methods of conducting to the hospital. The system of voluntary admission

must be extended, bringing within reach of many patients, who themselves often realize the necessity for treatment, the early care that insures a brief residence at the hospital. Such facilities are not only of great benefit to the patient, but are really a matter of economy to the state, shortening the length of care in the hospital, consequently lessening the expense and, it may be, restoring sooner a useful member to the community.

There should be a system of parole of suitable patients by reason of improvement or recovery, affording an opportunity for the trial return to self-support for a period of some months, during which time the patient may return to the hospital for further care and treatment, without a repetition of the legal formalities, should it be deemed necessary. The parole system should be combined with an efficient after-care agency, preferably a member of the medical staff or a social worker, who may have a certain amount of supervision over the paroled patient. Such an after-care worker may render service in advising the return of the patient, if indicated, in assisting in a change of habits or environment, in helping to obtain a suitable position, in arousing a kindly,

helpful attitude toward the former patient, in combating the feeling of suspicion or lack of confidence so often met with, and in adjusting difficulties in the home, family, or environment which otherwise might cause a return of the psychosis. The social worker also may be utilized in obtaining additional information from the friends and relatives of patients necessary for arriving at a proper diagnosis. In other words, the state hospital must be the center of advice for mental health, an active rather than a passive agency for good. Without such facilities for the furthering of mental hygiene, a state hospital for the insane cannot be considered fully equipped for adequate service to the public.

It is neither practicable nor essential to elaborate further as to the business methods or other details of administration. These must be left to the executive officer, whose training and experience should be such as to qualify him to solve such problems. And, finally, it must be realized that while present-day methods are undoubtedly the result of progress, the ultimate stage has not yet been reached. Radical changes in methods will be met with from time to time, it being only necessary to exercise judgment in adopting the same.

OCCUPATIONAL TREATMENT IN NERVOUS DISORDERS

Experience of a Lay Instructor—Forms of Occupation Best Adapted to Nervous Patients and Those With Mental Disorders—Newfoundland Hooked Mats

BY JESSIE LUTHER, OCCUPATIONAL INSTRUCTOR, BUTLER HOSPITAL, PROVIDENCE, R. I.

THE therapeutic value of occupation as a means of help and cure in nervous disorders is now so well known, and so much has been written of its theory and practice that extended comment on the subject may be superfluous. The practical experience, however, of one who has been engaged in such work from the early days of its general introduction may be of interest to those who have had similar experiences or are at the threshold of work along those lines, even though this experience is presented from a lay point of view, with no claim to consider the scientific aspect.

Today there are few institutions for the cure of nervous or mental cases, hospitals or sanatoriums, public or private, that lack an occupational department in some form. The idea, as many already know, is not of recent origin, for as early as 1843 such treatment was mentioned and practiced by the first superintendent of the Utica State Hospital, where a flourishing workshop has existed since the eighties, other hospitals and asylums having since adopted that form of treatment in certain cases. This treatment, however,

was for the most part employed with the really insane and almost exclusively for men, the occupation being brush- and broom-making and gardening. The general establishment of such treatment, however, as applied to women as well as men and in all phases and degrees of nervous as well as mental disorders, is comparatively recent.

My own experience began fourteen years ago when, in connection with Dr. Hall of Marblehead, a small sanatorium was established offering work instead of rest as a means of prevention and cure of such maladies. At the old "Ark" in Jaffery, Dr. Hall and I met as convalescents from illness, and during our long hours of leisure the subject was discussed and the project of such a sanatorium with its attendant details of suitable occupation became concrete and more than a theoretical possibility for the indefinite future.

As I had shortly before that time returned from Hull House and the superintendence of the Labor Museum with its weaving, spinning, and classes in pottery, basketry, wood-carving, etc., it was natural that such occupations, which were appar-

ently of interest to everyone and with the processes of which I was so familiar, should seem to me to be most fitting for our experiment, and it was decided to introduce the work along those lines.

The question of suitable housing was a problem, for facilities for working out of doors seemed important and houses in Marblehead with that possibility were scarce. It was May before we were finally established in an ideal location on the rocks at the entrance of the harbor, where wide piazzas almost overhanging the waves made open-air work not only possible but delightful.

This effort was tentative and at first more or less experimental. The sanatorium was planned, not for patients mentally unsound or for the more

of the town were engaged and taught weaving and pottery. They were present daily during working hours, and, besides actually producing, assisted the patients as they worked with them. These girls were paid regular wages, and their products, such as woven rugs, table covers, bedspreads, etc., were sold to help defray running expenses.

The work produced by the patients was in most cases excellent, and the pride in accomplishment and interest with its attendant benefit practically universal. Although, as I have stated, the sanatorium was started as more or less of an experiment, the results before the end of the first year warranted such extension as a small house in the neighborhood for a dormitory, a plot of land for gardening, and a small out-of-door workshop where wood-carving and the noisier forms of occupation could be carried on. A large pottery kiln in a building of its own was also substituted for the small kiln in the cellar of the main house. On



Fig. 1. Specimen of early work done at the Handcraft Shop.

extreme cases of neurasthenia, but for those who were on the verge of nervous collapse in need of some special interest to check its progress or who had passed through more extreme phases of the malady and, in a state of convalescence which is sometimes almost as uncomfortable as the disease itself, were in need of some stimulus to take them out of the inertia and self-consideration so characteristic of that stage and so liable to become chronic.

Realizing how persons in a sensitive state of mind are influenced by their surroundings and general atmosphere, it occurred to me that if they could be introduced at once into a workroom where beautiful and interesting things were being produced as a regular routine by normal people who would create a cheerful atmosphere, it would act as an incentive to their own efforts and tend to make them forget their real or fancied worries and their invalid state.

To this end four normal, cheerful young girls



Fig. 2. Hooked mat made by a patient at Butler Hospital.

every day of possible weather the piazza was filled with pottery- and basket-makers, while the thud-thud of the looms could be heard from the lower workrooms.

Many visitors came to inspect, among them numerous physicians from Boston and other cities much more remote, for general adaptation of occupational treatment was then a novelty.

From this modest experimental sanatorium known as the "Handcraft Shop" has been developed the well-known Devereux Mansion near Marblehead, the change of location and its accompanying expansion having been made a few years ago.

When the "Handcraft Shop" became fully established I took advantage of an opportunity to enter what seemed to me a more extended field for work along the same line, at Butler Hospital in Providence, R. I. Here the patients are not confined to the mildly neurasthenic or convalescent, but are often cases of actual dementia, some of them of a discouraging type.

During the twelve years of my connection with the hospital the personnel of the patients under my charge has been as changeable as a kaleidoscope, and the number occupied has increased

from eight in the original class to the present number of between forty and fifty. Only one patient has been with me from the beginning, a dear old lady of whom I am very fond. The only other patient of long standing joined the class in my second year. On entering the hospital she was supposed to have but a limited time to live. Her class membership was an experiment. She was the wife of a race-course book-maker, and her familiarity with her husband's calling influenced her choice of songs; sometimes when exhilarated her indulgence in race-course music and encouraging cries to imaginary riders made her connection with a class a problem. Time and patience were necessary to teach her to make a raffia basket, the only form of work she would attempt, but, the stitch once mastered, she has produced many baskets, all practically alike in size and shape. The choice of colors is her own, and most of her work resembles the proverbial "Joseph's coat." She works continually, and, although at times she remonstrates in strong language with an imaginary enemy, only a word is necessary to bring her back to her surroundings and only once in all these years have I been obliged to send her from the class. Her interest in her work is never-failing and her general mental and physical condition far better than on entering the hospital.

Although a great many interesting cases and cures have come under my notice, perhaps one of the most remarkable was that of a woman who for three years could scarcely be persuaded to make the least effort and whose interest in basket-making when finally aroused effected a veritable transformation beyond the hope of the most sanguine. In her case her improvement also had its bearing on the other patients in the ward, for her work was really beautiful and original, and her cheery enthusiasm and unlooked-for energy awakened the interest of many new patients in her constant association with them and was of much assistance in carrying on the special branch of work during the interval between class hours. The work was a joy to her, and even before her departure from the hospital became a source of needed revenue.

During the early days at the hospital my sympathies were so keenly aroused that the class work proved very exhausting. After twelve years' experience my sympathies are no less keen, but I can consider a patient as one to be helped and, in a difficult case, a stimulus to find a means of helplessness.

Occasionally I have been asked by those especially interested in occupational treatment if any rules could be given as guides in teaching. I can think of no rules except the obvious ones of un-

limited patience and unvarying cheerfulness—I might add tactfulness and vigilance, but those are also self-evident.

It has seemed an excellent policy to ignore as much as possible the fact that these people are patients and take for granted that they are interested in the things of ordinary life. Many are keenly alive to what is going on in the world, and there are few who fail to become interested in some degree in what is told them of people and events, but the personal element, of course, enters and it is necessary to choose one's subjects with care.

Whenever possible the patients are urged to use initiative—in the character of occupation itself, in designs if possible, and in choice of colors employed. In regard to the latter it is interesting to notice the colors chosen, pink, green, or blue being the average first choice. Yellow and orange are not so generally popular, in some cases actually disliked, and there is often a strong objection to purple and black, though light violet and pale yellow find more favor.

As regards the form of occupation, I have mentioned basketry in particular. Raffia basketry is very simple, and I often use it as a test in the case of new patients. If sufficient concentration is shown, a choice is given of other kinds of occupation as well, weaving, hooked mats, pottery, stenciling, etc., all of which have been successful with the class of patients brought to Butler Hospital. Other forms of basketry, of reeds or pine needles, are also offered, but raffia work requires the least effort for a beginner.

The occupational department occupies the entire upper floor of the Goddard House, once the nurses' dormitory before the addition of the nurses' home to the hospital. There is a large cheerful central room for convalescents, the privilege of occupying it sometimes being offered as a reward of merit to patients who are inclined to be noisy, in the effort to stimulate their self-control, for no disturbance is allowed in that room and there are many smaller rooms which make segregation possible for those in a less normal condition. There are looms of various kinds, and rugs and pattern-weaving made on them are really lovely. Stenciling with crayons made for the purpose has been popular from time to time. The method is simple and within the power of anyone not especially disturbed.

Pottery has in some cases proved of great help. There is something very quieting in the use of the plastic clay. One can see at once that mistakes are not irrevocable, and patients who doubt their power of accomplishment are content to give it a trial. It is also valuable in offering an oppor-

tunity for self-expression which is sometimes a relief or source of amusement to a disturbed mind.

A number of old-fashioned braided mats have been made, and this work, as well as rug-weaving, has the advantage of employing more than one group of patients. Only a few can successfully weave the rugs or properly sew the braided material into form, but many can prepare the material. Even disturbed patients tear it in strips; in fact this form of work appeals to some of them particularly; others sew the strips together and roll them in balls ready for use, while still others braid them.

I have found that colors are often a stimulus in engaging a patient's interest, and soft wool of lovely shades has proved an incentive to many to knit scarves or small shawls, offering occupation for the idle moments of the day outside class hours when other forms of work are generally employed. With this stimulus of color in mind I have for the past two years planned a May-day party for which the patients make May baskets of colored paper. They have been a great success and an excuse for an annual tea party.

Perhaps one of the most interesting forms of employment is the hooked mat, also a revival along with the braided rug of colonial days. This kind of rug is found in the rural districts of northern New England, but especially in Nova Scotia, New Brunswick, and the northern provinces.

My first acquaintance with them was in Newfoundland. Until the past two years my summers, since my connection with Butler Hospital, and two winters as well, have been spent in Newfoundland and Labrador in connection with the Grenfell Mission, where as superintendent of the industrial department I have established weaving and other industries at St. Anthony and small villages on the Newfoundland and Labrador coast. In connection with this work I found the hooked mats which in that country were purely utilitarian, being the only covering for the floors of the average native house outside the city of St. John's and the few real towns. These rugs are used for warmth as well as decoration and are made from any rags available—the remains of old clothing and bits of remnants sold by the local trader. The workmanship is often beautiful, but the coloring and design very ugly. The rugs were often brought to me and to other members of the mission staff for sale, but for the most part their purchase was only a charity and no outside market for them would be possible except as curiosities and examples of native work.

One summer about nine years ago it occurred to me that if this excellent workmanship could be turned to account by providing attractive, simple

designs of a local character, subjects with which the workers were familiar, and substituting coloring that would harmonize with ordinary household furnishings for the crude, nondescript coloring of the native mat, a market could be found outside Newfoundland for the product and the makers paid for their work outright with no responsibility as to material or choice of coloring. The designs which I made myself were local in character, reindeer, seal, walrus, ducks, komatik, and dogs, etc., treated conventionally as a border, the material of as fast colors as possible and for the most part home dyed. These rugs could be made at home during the long winter and particularly what is known locally as "the matting season" of late winter and early spring.

Every fall on my return from the north I brought with me a shipment of products from the industrial department for an annual sale in Providence, Boston, or New York, and these hooked mats were so popular and so many orders received for them that since being unable to go north during the past two years and having resigned from the mission, I have given out mats with the same designs here at home, not only to patients of the hospital but to many of the needy Italians and others in this city in need of work that may be done at home to eke out the family earnings. Some of the workmanship has been as satisfactory as that of the north, and among the best is the work of one of the patients, a cut of whose latest finished product is added to this article, while she is fast completing another of a different design.

Although much of the product of the class room, such as woven rugs, table covers, pillow covers, baskets and plain sewing, are for the use of the hospital, a large number of articles are for the annual sale, work with a special object usually acting as an incentive and stimulating enthusiasm in the workers' efforts. The proceeds from these sales have been for the benefit of the Visiting Nurses' Association, the Red Cross, and the British Relief. Since early summer we have joined the great army of those who are striving to "do their bit" in this great emergency by knitting for the Red Cross and the Navy League. To work for the soldiers is the greatest incentive, and some of the patients are rarely without a piece of gray or khaki knitting in their hands. One woman alone has knitted fifteen sweaters, and we have been able to send well over a hundred to the Red Cross and a lesser number to the Navy League, besides many mufflers and wristlets, and several patients are now making helmets. Only a few socks have been made, and as a rule by those

who were already familiar with the process before entering the hospital, the intricacies of the knitted heel in most cases requiring too much mental effort. A number of patients are incapable of any work more difficult than plain sewing, and for those the Red Cross has provided articles needed for hospital comforts, so all are able to do their part.

The grounds of Butler Hospital are large and very beautiful, and as soon as the warm, spring days permit, the class is taken to the lawn where it is possible to continue all kinds of work except weaving during the fair days of summer.

To know that the occupational form of treatment has been found entirely successful, one need only be sufficiently interested to follow the reports of institutions having already given it a trial.

For my own part there has been the experience of knowing many whom I first saw hysterical, unnaturally passive or without self-control, with excited or dull, expressionless faces, sooner or later arrive at a day when as normal, self-controlled persons they have returned to their own environment. It is true there are those who have been unable to endure the contact with everyday life and have returned for another period of help, but others are happy with the members of their family around them or in the midst of normal, absorbing work in the business world and with expressions of content on their faces that at one time seemed impossible one could ever see there. If pessimism ever existed in regard to this treatment a realization of cases such as these would convince the most skeptical that it is worth while.

HOSPITAL HOUSEKEEPING, ITS WORRIES AND CARES*

Sewing Room, Laundry, and Cleaning Service—Care of Walls—Wages of Various Classes of Employees—Saving Due to the Fact That Employees Are Not Fed in Hospital

By MARY A. JAMIESON, R.N., SUPERINTENDENT, GRANT HOSPITAL, COLUMBUS, OHIO.

WHEN I was requested to read a short paper on housekeeping, I rather struck my sense of humor, for of all the various branches of work in the hospital, this is the one that is most distasteful to me.

Each hospital, I find, is a law unto itself along this line. Some think that a good housecleaning once a year is all that is necessary for every purpose, and I have about decided that, in many instances, the cleaning at the present time must be governed by the income of the institution, for without a good income no hospital can, at the price of supplies today and the high cost of labor, keep up its housekeeping as it might wish. But I have decided just to give you some idea as to how we have our work done, also the cost.

We have a first-class housekeeper, whose work is simply to look after the housekeeping. By this I mean the keeping of the hospital clean, looking after the linen when it is returned from the laundry, taking charge of the sewing room, which includes the making and mending of supplies, also the employing of all the help used in this department, as I always think it best for the head of each department to both employ and dismiss all employees in that department.

The sewing room comes first on the list, as here the housekeeper makes her headquarters, having a telephone that is connected with every floor, as well as outside, and here all calls come for the

housekeeper. The sewing room has three motor machines and is the adjoining room to the laundry; here every morning all torn or worn linen is carried and the first thing done in the sewing department is the repairing of this linen; after that the new articles are made up. These include the aprons worn by the student nurses, but not the dresses, which are sent out. The three women are paid \$8.32 a week; they room outside, but have their meals at the hospital. The hours are from 8 a. m. to 5 p. m. with one hour for lunch; no work on Sunday; a half day off every other week.

Since we are dealing with the housekeeper's share of the laundry, it might be wise next to mention our linen man, as he is called. This man brings all the linen from the floors to the laundry (owing to the plan of the building, we have to carry all the linen from the floors to the laundry). He also takes back in the morning all the clean linen to run the floors, and again in the evening makes a trip to see that there is plenty of linen for the night nurses. This man also takes care of the garbage cans, of which we have two for each service room. In this way, after the can is emptied, it is allowed to stand in the air for some hours before being returned to the floor. Of course, each time the cans are emptied they are washed out with boiling water and made perfectly clean. We pay this man \$14 a week.

Now, for the cleaning, on each floor we have a porter, a maid to look after the rooms, and a

*Read before the Fourth Annual Convention of the Ohio Hospital Association, Columbus, Ohio, May 28-30, 1918.

maid in the serving kitchen. The porter (this man is colored) works from 7 a. m. to 5 p. m. with one hour for dinner; he goes out for his meals. He is paid from \$12 to \$15 a week. He cleans the hall floors, the service rooms, the serving kitchen floor, laboratory, bathrooms, all the windows of occupied rooms, and the hall windows. He also uses the vacuum cleaner on the rugs and carries to the floor the chopped ice for the ice caps.

The maid on the floor is a white woman. She starts to work at 7 a. m. and has one hour for dinner (going out for this) and stops work at 3 p. m. One day out of every nine she remains on duty to help sweep rooms emptied after 3 p. m. and works half a day on Sunday. This woman sweeps and washes all occupied rooms. She is paid \$8 a week.

Next is the maid in the serving kitchen. She comes on duty at 8 a. m. and goes out at 10 a. m., has her dinner at home, and returns for work at 12:30, gets through about 2:30, returns to do up the supper work at 5:15, and is generally done about 6:30 p. m., making in all about six hours a day. This maid washes the dishes, and is responsible for the condition of the entire serving kitchen aside from the refrigerator. She is paid \$7.50 a week. Sunday work is just the same as any other day.

At our hospital when the patients go out we wash the walls of all rooms if they have been occupied for over a week. In this way the rooms never get very dirty and they are not hard to clean. Our routine is as follows:

When the patient leaves the room, the nurse takes care of all the linen, sees that every part of the work that belongs to the nursing department is done, and then the head of the floor notifies the office and the housekeeper that the room is empty. The maid on the floor sweeps the room and then the wall-washers (we keep six who do no other work than washing the walls in the hospital and the windows in the empty room), take charge, wash the walls, and scrub the floors. The wall-washers work nine hours a day and a half day on Sunday. We pay them from \$14 to \$16 a week.

Then the maids, of which we keep three for this work, go into the room, wash the bed and the furniture, do up the room just as any hotel room is finished, and report the room to the office and the housekeeper as ready. This may seem like a great many people doing the same thing, but it is not; each person does her part, and after months at this work, they are able in the shortest period of time to report in a room as ready. No person tries to do the other person's work; each

just does her own and gets out and is ready for the next room. For instance, each of the little maids knows her own work; one washes the bed while another washes out the wardrobe, and the dressing table; both then make the bed so as to save walking around it. Meanwhile the third maid changes the window sash curtains, puts on clean stand covers, dusts the chairs, and goes out to get the linen ready for the next room. In all it takes about ten minutes after the room is turned over to them.

If there are not rooms enough to keep the three maids busy, they set the patients' trays, clean the linen closets, and try to make themselves in general very useful. They are paid \$6 a week and have their noon meal at the hospital, getting it from the nurses' cafeteria, but eating downstairs. These girls wear white and are always perfectly clean; they are girls from good homes. They work half a day on Sunday (four hours). Right here it might be wise to state that after three years of just such washing, our walls look as well as if they had just been painted this year, but I have always been exceedingly careful about the preparation that is used on the walls; no experimenting is allowed. If any agent wants us to try out his material, I get a sample and send it away and have it tested to see if it will hurt the paint. In this way we are often saved the need of painting, as many of the so-called cheap preparations are good to take the dirt off, and equally good to take off the paint. We use a preparation of linseed oil soap; if we cannot get it we use other vegetable oil soaps, allowing 40 pounds of soap and 4 pounds carbo powder to 40 gallons of water. To a bucket of water we add about 6 ounces of the soap solution and wash with a soft cloth.

The walls are painted with a high-polish enamel, and we find that it pays to use the very best, as it is not alone the price of paint that costs, but also the cost of putting it on. We have a permanent painter, who keeps up the little repairs that arise about a hospital. He is a union man and is paid union wages. A permanent carpenter and plumber are also kept, being paid union wages.

But to go on with the cleaning, a man is kept busy from morning until night just washing steps. Every step in the hospital is washed at least once a day and those that are used quite frequently are washed three times a day. I have never known this step man to do any other work around the hospital, but he does this one thing well, and that means a whole lot. Just keeping the water from going down the side of the step and in this way marking the wall means so much to the housekeeper. This man is paid \$12 a week.

The woman in charge of the linen room is also under the housekeeper. She, after getting the house count, arranges the linen to be taken to the floors, sorting as she goes along. This woman is paid \$8 a week.

Last comes the nurses' residence, this is also under the housekeeper, but, as we have a good woman in charge of the residence, it makes the cares of the housekeeper, for that part of the work, much lighter. This woman in charge of the residence looks after the linen of the home, and also takes charge of the man and the maid who are kept there to do the work. She is paid \$35 a month and maintenance.

We feed no one at the hospital but the office force, the women in charge of the nurses' residence, the three sewing women, the three little maids, the nurses, and the nursing officers and the house doctors. During the last year we have found that it has paid us not to feed the help.

Owing to the high cost of food, the difficulty of getting a variety, and the need of more help to serve the seventy odd employees who used to eat here, we find that we would have been out more money than by paying the difference in the salary. At first the help did object to the arrangement, but in time they came around nicely.

I hear of other hospitals saying that they cannot get nurses, and feel that our secret of success along that line is partly due, no doubt, to the fact that the nurses are not supposed to do maids' work. They are taught how to clean, but they are not at the hospital for a course of housekeeping, so we do not expect them to do it.

I do not think it will be necessary for me to say that the housekeeper is one of the busiest women in the hospital. I was going to say her hours were—but really think that she has no hours, just keeps on until everything is done, if such a thing is ever true about a hospital.

SELF-GOVERNMENT FOR THE RESIDENT MEDICAL STAFF

A Plan Introduced at New York City Hospital—Trend of the Time Toward Democracy in Educational Institutions as Elsewhere—First Attempt to Introduce Self-Government into the Hospital

By CHARLES B. BACON, M.D., MEDICAL SUPERINTENDENT, NEW YORK CITY HOSPITAL, DEPARTMENT OF PUBLIC CHARITIES, NEW YORK CITY.

THE medical service of the modern hospital is not only a place for fitting young men recently graduated from our medical colleges to care properly for the sick; it is also an educational institution. At the termination of an internship these men go forth to engage in the activities of life with a personal responsibility, each one acting his part in the many medical, social, and economic problems, each an honored member of a noble profession. In order best to meet these obligations young men need to have placed upon them, during the years of preparation for life service, responsibilities associated with their training and experience. Self-government, as it appears to me, has a practical application in its relation to young men; I might say, equally so to young women; and I predict that a modified form of self-government will in the near future be introduced in many of our hospitals and schools of nursing.

Self-government, as applied to student bodies, has for many years been in successful operation in many of our leading universities, colleges, and schools. In certain educational institutions well known to me, it is regarded by the faculty and student body as practical and fundamentally correct, receiving mutual approval. Some months

ago, my interest having become quickened on this subject, and a question arising affecting somewhat unusually the conduct and discipline of our intern staff, I asked myself, "Why is not a modified plan of student self-government practical in its application to the members of the intern staff?" A large portion of our interns have an academic, as well as a professional, degree. Furthermore, their academic and professional studies have been pursued in educational institutions where self-government is already in operation.

FIRST INTRODUCED AT CITY HOSPITAL

So far as I know, this is the first effort to introduce self-government as it relates to the intern staff of hospitals. I decided that it might well be initiated at this hospital. Accordingly, the plan was experimentally placed in operation approximately one year ago. So acceptable and satisfactory was this plan that it recently, at my request, received the official approval of Commissioner Wright.

I conceive it to be the duty of every administrative officer, whether he or she is charged with the responsibility of directing the affairs of a hospital or school of nursing, ever to keep in mind that the status of the intern has changed, as well

as the spirit of the age, since we were interns. Furthermore, the whole world is turning toward democracy. I am quite familiar with what has been said concerning interns during the past twenty years, regarding their habits of conduct, welfare, discipline, their relations to the various officers of the hospital and school of nursing, the attending staff, the patients, and the public. For the greater part, nearly all one reads and hears on this subject indicates that interns require close supervision and have a veritable will to violate established rules. I have long since concluded that members of all professions dislike rules, and rules established for disciplinary measures are, to say the least, unwelcome.

To the medical administrative officer is given an unusual and special privilege of relating himself most intimately with the members of the intern staff. This relationship should be one of advice and helpfulness, as well as corrective. For twenty years my work has been thus intimately associated with medical students and recent graduates, not only as a medical administrative officer, but also for seven years as instructor and lecturer at the Long Island Medical College, also beside teaching in the wards of the Kings County Hospital. I appreciate that these men soon realize that the practice of medicine is a sacred art, a responsible calling, and requires the best they can give. Thus their habits of life, work, and play are measured by a scale of justice to all members of the hospital organization, and here let me say that an efficient organization and fraternal cooperation are fundamental requirements.

No member of the hospital family comes in such intimate touch with the intern as does the superintendent. Our interns receive appointments following competitive examination, conducted usually in February, and serve as junior, senior, assistant house, and house officer, for a period of two years. Prior to their entrance on duty, they assemble in my office. This is my first opportunity to speak with them as regards their conduct, work, and welfare, as it relates to each and to one another, and to the entire hospital family. From this moment they are made to feel that they are officers of the hospital and members of our family, that each member bears a definite relationship and position in our hospital organization. In this cordial, helpful, and mutual relationship it is possible for all to live and work.

Honor appeals to all. This has always been impressed upon me from early boyhood days. I expect that a modified form of self-government, based on the honor system, will be the next for-

ward step in our professional administration, particularly as it relates to the resident professional members, whether students, doctors, or nurses. It may not be advisable to adopt this plan in toto at once. Preparation must be made, and the plan acceptable to all. Conferences with the house staff and their cooperation are vital in preparing the way and adopting the plan. This is always necessary whenever a change is to be made. We did not launch forth on this plan without devoting ample time and consideration to it. From the very beginning we received encouraging support. At our final conference, when a vote was taken, it was unanimously and enthusiastically approved, each and every member pledging his loyal support. Throughout the consideration of this plan I was encouraged by the support and cooperation accorded by Commissioner John A. Kingsbury, First Deputy Commissioner Henry C. Wright, and Mr. Lyman Beecher Stowe, secretary of the department. Their helpfulness, together with the splendid spirit of cooperation manifested by every member of the house staff in this and other matters of mutual benefit, is gratefully acknowledged. The preparation of our plan of self-government, its aim, constitution, and resolutions, received long and careful study, and will, I believe, serve as a guide and control in the conduct, work, and welfare of our intern staff.

I am pleased to present to the readers of THE MODERN HOSPITAL our plan of self-government.

PLAN OF SELF-GOVERNMENT

Drafted by Dr. Charles B. Bacon, Medical Superintendent, and the Members of the House Staff, New York City Hospital, Department of Public Charities, New York City

Thoroughly believing that a plan of self-government based on the honor system, and already in satisfactory operation in many of our leading universities, colleges, and schools, is fundamentally correct, and pledging ourselves to loyal obedience to such a plan, we enact and submit to the commissioner, Honorable John A. Kingsbury, and deputy commissioner, Honorable Henry C. Wright, the following aim, constitution, and resolutions governing the resident medical staff of the City Hospital.

AIM

To observe those proprieties of conduct and courtesies in our relations to one another, to all officials of the hospital, the nurses, the patients, and the public, as shall preserve at all times the dignity of the house staff and the honorable standing of the hospital.

CONSTITUTION

Article 1. The name of this association shall be "The Resident Medical Staff Association for Self-Government."

Article 2. The purpose of this association shall be the government of the intern staff.

Article 3. The association shall be composed of active and associate members. Active membership includes those having received a regular appointment; associate mem-

bership includes those serving as special assistants, substitutes, and pathological interns.

Article 4. Active members only shall be qualified to hold office in the association. However, associate as well as active members shall be entitled to vote.

Article 5. The medical superintendent, together with the chairman of the executive committee of the medical board, and the assistant resident physician, shall be ex-officio members. It shall be their duty to give counsel and advice. They shall attend meetings on invitation, also whenever matters of extraordinary or special importance arise.

Article 6. Section 1. The association shall have power to deal with all matters concerning the conduct and welfare of the staff members.

Section 2. The association shall have the power of inflicting penalties, to enforce its decision, even to the extent of recommending the expulsion of a member to the medical superintendent.

Article 7. The house staff shall hold meetings in the staff room, Janeway Hall, at least once a month.

Article 8. Section 1. The executive power of the association shall be vested in an executive committee of five members—one member to be elected from and by each division (house, assistant house, senior and junior)—and one shall be elected at large by the entire house staff. The medical superintendent, together with the chairman of the executive committee of the medical board, shall be members ex-officio.

Section 2. This committee shall elect a president, a vice-president, secretary and treasurer.

1. The duties of the president shall be to call together and preside over all meetings of the association and the executive committee.

2. The duties of the vice-president shall be to assume the duties of the president in his absence or at his request.

3. The duties of the secretary shall be to keep the minutes of the association and a list of the members, to post notices of the meetings, and to attend to the correspondence of the association.

4. The duties of the treasurer shall be to collect all dues and assessments established by the house staff.

Disbursements of \$5 or over shall be made only upon the recommendation of the house staff. Disbursements under \$5 may be made upon the recommendation of the executive committee.

The treasurer shall post on the bulletin board at Janeway Hall the amount due from each member, also on the first of every month a complete financial report.

Section 3. 1. The officers of the executive committee shall be semi-annually elected by ballot, by the association, on the 15th day of June and the 15th day of December (or on the following day, should this day fall on Sunday or holiday) they shall enter upon their duties immediately.

2. The executive committee shall bring to the attention of the house staff, assembled in session, any suggestion which shall have been brought to the attention of the committee by any member of the house staff, providing this suggestion receives a majority vote in affirmation at a meeting of the executive committee.

3. The executive committee shall take under consideration all matters relating to the conduct and welfare of the house staff.

4. The executive committee shall settle all differences arising between members of the house staff. Appeal from such decision may be made before the house staff in session. Until such decision shall have been appealed

and acted upon by the house staff, the decision of the executive committee shall remain in force.

5. Any member of the executive committee may be impeached by a majority vote, and removed from office by a two-third vote of the assembled house staff. Election to office, created by such vacancy, shall be by and from the interested division, in the event of a divisional represented vacancy, and by the assembled house staff in the event of a vacancy in the office of the representative at large.

Article 9. Section 1. The legislative power of the association shall be exercised by the whole house staff. One-third of the members shall constitute a quorum.

Section 2. A meeting of the association may be called at any time by the president, and must be called by him on the application of three members or the medical superintendent. Should the president be unable to call a meeting, it shall be called by the vice-president.

Section 3. The rule of a majority shall prevail in all meetings where a quorum of the association is present.

Article 10. Section 1. The judicial power of the association shall be vested in (1) the association, sitting as a judicial body—this body shall constitute the highest court, wherein the rule of the majority, consisting of two-thirds of the members of the association, shall prevail—and (2) the executive power, constituting the lower court, before which all matters must first be brought, and from which an appeal may be made to the whole association, sitting as a judicial body.

Section 2. In extraordinary cases, before a decision has been reached, the association sitting as a judicial body, at the request of the executive committee sitting as a judicial body, and upon an affirmative vote of two-thirds of the members of the association, may delegate its supreme jurisdiction to a special court, consisting of the executive committee, the medical superintendent, and the chairman of the executive committee of the medical board. The latter two members shall, if deemed by them advisable, present the matter, for final and official action, to the commissioner.

RESOLUTIONS

Relating to the Resident Medical Staff Plan of Self-Government

1. *Resolved*, That the constitution and resolutions of the association be semi-annually read aloud by the secretary to the members of the association, once during the month of June, again during the month of December.

2. *Resolved*, That two days previous to any meeting of the association a notice of said meeting be posted on the house staff bulletin board at Janeway Hall, and twenty-four hours previous to the meeting a complete list of subjects to be discussed be likewise posted. In cases requiring immediate or private action this regulation may be set aside by the president.

3. *Resolved*, That the executive committee, sitting as a court, be empowered to require testimony from any member of the association.

4. *Resolved*, That members of the house staff shall register their name, date, time of departure, time returned, together with name of substitute, in the house staff time book to be found at the hospital, in the bureau of information.

5. *Resolved*, That we declare our intention and will to strictly obey all rules heretofore promulgated, or that may be promulgated by the commissioner, affecting the conduct and welfare of the house staff.

6. *Resolved*, That each member of the house staff shall be provided with a copy of the constitution and resolutions.
7. *Resolved*, That application for leave of absence shall be submitted to the medical superintendent on the regular form for this purpose. This shall be permanently filed.
8. *Resolved*, That no member of the house staff shall entertain visitors without having first secured the consent of the medical superintendent.
9. *Resolved*, That the executive committee shall exercise supervision over the residence of the intern staff, the rooms, hallways, bathroom, staffroom, and library. This committee shall endeavor to see that the house rules are carefully observed by all members, such as punctuality to meals, visitors to the home, quiet, etc.

10. *Resolved*, That the house staff service schedule shall be tentatively prepared by the assistant resident physician for the consideration and approval of the house officers, not later than the evening of the twenty-fifth of the month. When agreed upon, the schedule shall be posted on the bulletin board at Janeway Hall, for the attention of the association, and shall be delivered to the medical superintendent for his approval, and typing, not later than noon of the last day of the month.

AMENDMENTS

This constitution and these resolutions may be amended or added to at any regular meeting of the association assembled in session, by a two-third vote.

MEMORIAL HALL OF BUFFALO GENERAL HOSPITAL

Protection of Patients From Disturbing Noises One of the Foremost Thoughts in Planning—Every Comfort in Patients' Rooms—Harmonious Color Effects—Operating Room Isolated From Patients' Rooms

By EDWARD F. STEVENS, ARCHITECT, BOSTON.

DURING the past twenty-five years the Buffalo General Hospital has made rapid growth and noteworthy improvements. Its capacity has increased from 125 to 375 beds. The plant has been practically rebuilt. First, the east pavilion, a beautiful structure of terra cotta and brick, con-

room; and now, just completed, the new pavilion for private patients, to be known as "Memorial Hall."

In the designing of this Memorial Hall, the general outline and type of architecture of the east pavilion was duly considered and adopted. The plan



Fig. 1. Memorial Hall, the new private patients' pavilion of Buffalo General Hospital, Buffalo, N. Y. Edward F. Stevens, architect.

taining wards and rooms, an operating department, and laboratories; next, the children's building; then within a twelvemonth the new service building, complete with up-to-date equipment and conveniences for the staff, and a nurses' dining

was given much study by the superintendent and the architect so as to come as near perfection as possible for the housing of the sick.

The new building, caring for sixty-two patients, is but a part of the entire pavilion, as the connect-

ing corridor, with its large day room and airing balcony, owing to existing buildings, has not yet been built; and until this has been finished, the plan will be incomplete. The room portion of the pavilion, however, is quite complete.

One of the foremost thoughts in mind was to protect the patient from the usual disturbing noises caused by elevators and trucks and the clatter of dishes and equipment. To accomplish this, the noisy portions of the unit—the elevators, the

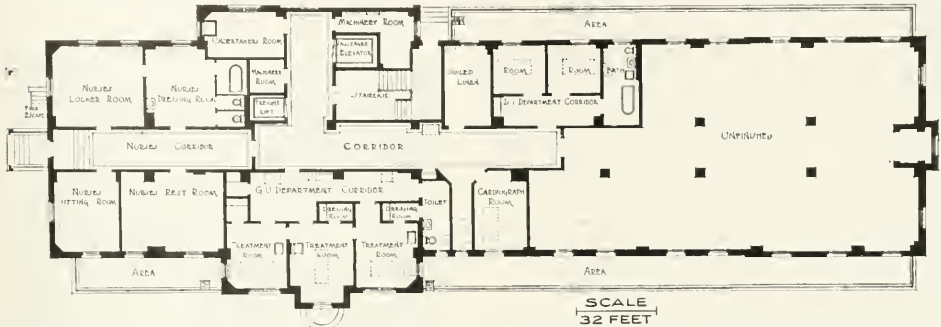


Fig. 2. Ground floor plan of Memorial Hall, containing the genito-urinary clinic and the psychopathic department for treatment of the delirium tremens patient.

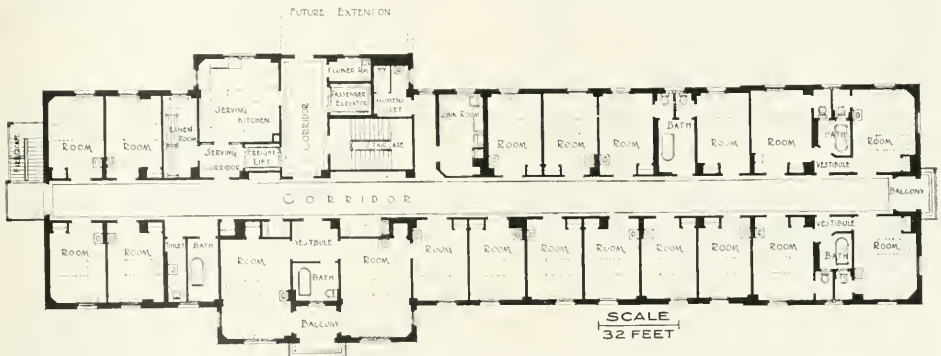


Fig. 3. Typical bedroom floor plan of Memorial Hall. Note how quiet is insured by the placing of the noisy portions of the unit, such as elevators, sink room, and serving kitchen, on separate and cross corridors, away from the approach to patients' rooms.

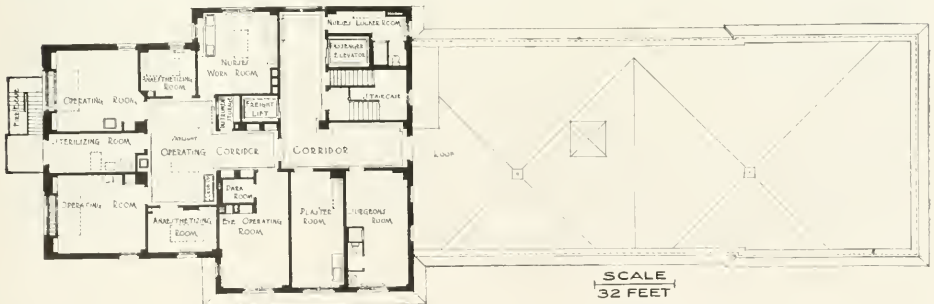


Fig. 4. Operating floor of Memorial Hall.

While most well-planned pavilions for the care of private patients are much alike in plan and equipment, in this building there are some features which should be of interest and should repay a careful study.

sink room, the serving kitchen and the staircase—are placed so as to open on separate and cross corridors, away from the approach to the patients' rooms. The partitions enclosing patients' rooms are deadened with an insulating quilt on

both sides of the metal studs, preventing the sound from one room being transmitted to another room. Floor noises are practically eliminated by the use of cork tile for all corridor floors, and linoleum for the floors in patients' rooms. All utility rooms are vestibuled from the main corridor.

The patients' rooms are planned for every degree of comfort. The base is gray terrazzo, the floor of gray "Jaspe" linoleum, and the walls tinted in warm, pearl gray. The color effect is carried out even in the electric lighting fixtures.

Each room is provided with a special pattern hygienic lavatory for washing under running water, a closet, telephone connection, and wall plugs for bedside lights and nurses' calls.



Fig. 5. Typical private room in Memorial Hall, showing type of bed, box mattress, and general utilities.

There are general toilets and baths for the nurses, the doctors, the patients, and the visitors. Several suites of rooms have private baths.

The sink room on each floor is completely equipped for all services to the patient not provided by the serving kitchen and the linen room.

The silent electric light system has been installed for the calling of nurses by the patient, with a recording device showing the time elapsed between the making and the answering of each call. The signal is also given by a red light over the door of the room and by an annunciator signal over the desk of the head nurse. The call can be canceled only by the nurse going to the head of the patient who sent the call and using a key to reset or release the call.

The serving kitchen is equipped with all modern conveniences for preparing and serving food in the most delicate way. The sink rooms are provided with sterilizers for instruments and basins. A medicine closet, with special plumbing, is placed on each floor.

The operating department for the pavilion is most complete, located, as it is, on the top floor, away from the patients. There are three operating rooms, well lighted and supplied with built-in cabinets for the storage of instruments and supplies. There is a plaster room convenient



Fig. 6. Entrance foyer to operating suite, Memorial Hall, showing surgeon's scrub-up, entrance to sterilizing rooms, etc.

to but out of the operating area. The surgeon's scrub-up is in the corridor, near the operating rooms. The nurses have their work room, dressing room, and toilet. The surgeons have their locker room and toilet.

The usual sterilizers are provided in the sterilizing room, except for the water boilers. The water for all clinical purposes is distilled in the



Fig. 7. Operating room of Memorial Hall, showing direct-indirect radiator behind glazed screen, built-in cabinets, and distilled water reheater.

tower and piped to the various operating rooms, where it is reheated by steam to the desired temperature.

In the basement or ground floor will be found the genito-urinary clinic and a small but complete psychopathic department for the treatment of the

occasional delirium tremens patient, with a continuous bath. On this floor also will be found retiring rooms for the special nurses.

The elevators are of the latest type, with special hospital cars and all safety devices.

The group plan is such as to make available large yards to the south. These will be developed into lawns with groups of shrubbery, beautifying the appearance of the institution from the street as well as from the patients' window.

LITTLE JOURNEYS TO PLACES AND PEOPLE WORTH KNOWING

The Second Little Journey—To Grant Hospital, Chicago, an Efficient and Well-Managed Institution in Which Sympathy and Understanding of the Individual Are Key-notes—Some Factors in Its Success

BY MARGARET J. ROBINSON, R.N., FIELD EDITOR OF THE MODERN HOSPITAL, CHICAGO.

GRANT HOSPITAL, Chicago, was organized in 1883 for charitable purposes, primarily to give care to the sick who could pay little or nothing. It was then housed in a small building erected as a residence. Since then the scope of its work has been enlarged to include a hospital

ported, principally by Americans of German descent, through annual memberships, bequests, and legacies. It has an active woman's auxiliary, which buys linens and needed equipment. The present building was made possible by the generosity of Catherina Seipp, who gave the necessary



Fig. 1. Grant Hospital, Chicago. View showing the garden.

of one hundred and fifty beds and an out-patient department which gives high-grade service to pay patients; but over 30 percent of all cases treated are free bed cases.

The hospital has a gradually growing endowment, which gives it an income of a few thousand a year. The institution is maintained and sup-

ports funds in memory of her husband and son. The building was opened for patients February 16, 1913.

The building presents a dignified exterior of solid construction, and is architecturally attractive. Although it is in the congested North Side district of Chicago, the architects so planned it on

a triangle that enough ground space was left at the rear to have green lawn and shrubs and a place for recreation and the baby tents.

The hospital, since its incorporation in 1883 until quite recently, was known as the German Hospital of Chicago, but at present the bronze name tablet which has ornamented the front of the building is being melted down and is getting ready for its new name. The rubber door-mat at



Fig. 2. One of the light, roomy kitchens in Grant Hospital.

my visit still bore the legend "German Hospital," but I was told that this was to be changed by adding a T to the "German" and taking out the E and the M.

The day I visited the hospital, the assistant secretary of the board, Mr. Dilg, who is an official Liberty bond salesman, told me that the employees of the hospital had bought \$5,900 worth of bonds of this last issue. The service flag carries thirty-two stars, twenty-six for the men in the medical reserve and other branches of the service, and six for the nurses over there.

Miss Lewis, the superintendent, was at lunch when I came in, but she finally appeared, attended on the right side by a nurse asking questions, in front by two visitors who wanted to inquire for a patient, on the left by an intern asking more questions and in the rear by one of the girls in the office, who was trying to get her to the telephone, and both of her hands were busy knitting on a khaki brown sweater.

When she found time and breath to speak to me, I said, "When in the world do you get time to knit sweaters?"

"Why not?" said Miss Lewis. "I knit a sweater and a cap for every man who goes from here into war service, and they all write to me and I write to them."

"Do you ever sleep?" I asked her, and she said:

"Oh, yes, about six hours every night; that is enough for anybody." I thought, however, that

it was not everybody that could do with the same amount of sleep that was needed by Miss Lewis and Thomas A. Edison.

Soon Miss Lewis and I started over the building, beginning in the lower regions. Down in the engineering department, where the powers that be run the heating plant and laundry and things in general, everything was greased and shiny and busy, and the refrigerating plant thick with its usual heavy frost.

The laundry was busily grinding out clean sheets and towels and nurses' clothes, and the giant mangle ironing things on both sides with very little human help. Soiled cotton is washed and tumbled here, and much of it is saved in that way. In the sorting room the steel cupboards were black on the inside, and the piles of accurately folded linen stood out in strong contrast. I should think that this would simplify the work and give less eye-strain to the people who have to work here all day.

The kitchens are big, roomy, light, and well equipped with everything to make the work as easy as possible for the workers. A man who had lost one hand was mopping the floors, and doing it well. Miss Lewis said that he was one



Fig. 3. Maternity ward in Grant Hospital, with a view of the sectional cart designed here for the transportation of babies in their baskets.

of her best house-men, a permanent employee. In fact, she only wished she could get more like him and another partial cripple, a man with only one leg, who is also on the roll of permanent employees.

There was a pleasant staff and nurses' dining room. Miss Lewis says that restraint and discipline are all off in this room during meals, and that the interns and nurses and office employees may talk and laugh and relax their dignity while they eat.

On the first floor in the rear, and having its own separate entrance, are the out-patient depart-

ment, the pharmacy, and the radiographic and pathological laboratories. A full-time salaried pharmacist, a roentgenologist, a pathologist, and an assistant are employed; also a social service worker. There is plenty of equipment to do any diagnostic work needed.

The hospital is provided with a Pfaudler glass enameled linen chute, which can be water-flushed and cleaned; a light call system for patients; and the still small voice which announces in the cor-



Fig. 4. Nursery in Grant Hospital, with the specially designed baby dressing table in the foreground. Note the convenient height of this table.

ridors and the operating rooms that "Dr. Jones is wanted at the telephone, please."

The floors everywhere are covered with battleship linoleum. The private rooms are attractive and well furnished and made homelike by the curtains of sunfast wash material, rose-colored in the rooms on the north side, blue in those on the south. There are no shades on the windows, and ventilation is secured by the inlets from the curtained French windows and the outlets of the curtained transoms above them.

In the obstetrical department, which is a most busy and interesting place and a department which has been a particular success in this hospital, there are two delivery rooms. There had been sixty-six arrivals in the month of March, I was told. I asked what happened when three new citizens took it into their heads to come to town all on the same evening, and Miss Lewis said, "Oh, we manage all right; if the delivery rooms are both busy, and a third case comes in, we have a big wide cart we can use, and everything else is right handy up here." Sixty-six babies in one month in an hundred-and-fifty-bed hospital certainly shows the confidence of the doctors and the public in that obstetrical department.

In the hall we passed the sectional cart designed here and used by the young ladies and gentlemen in this department to motor to their lunch.

The nursery, of course, was the most interesting place in the whole hospital. On the shelves around the room, in the wire sandwich baskets, were forty-two new live babies. They were all quiet and contented except two. These two were not sick, and didn't have any especial reason for crying, they just wanted someone to notice them.

There were two "teenie weenies" in the incubator. Both were doing well, and one of them was making a brave attempt to make himself heard. This one was a premature of only six and a half months, but the nurses seem to think that he is going to "make it" and grow up like other folks.

The table on which the babies are cared for was designed and made especially for this room. It is 36 inches wide and 36 inches high. It is built something like a large flat-top desk, of white enamel finish and is long enough to hold half a dozen babies at one time. It has drawers on both sides in back and front. These contain everything in the way of clothes and toilet accessories that the babies need. The table has an endowment of its own, and bears the name-plate of the donor on the side of it.

In a small adjoining room there are warmed nickel plates where the babies are washed and get their shower baths. Of course, the patients



Fig. 5. The roof-garden of Grant Hospital, with its latticed pergola.

in this department are all thoroughly labeled so that they won't get mixed.

The operating suite was another busy place, and a force of nurses and orderlies were cleaning up after a long morning's work. This department has everything about it to indicate good work and plenty of it to do.

The roof garden is delightful. It has a pergola with latticed sides all around it, and tiled flooring. Several patients in wheel chairs were up here sunning themselves, and over in a corner was a three-months-old orphan baby in a carriage. You

know how hospital people love these orphaned babies and make much of them. This baby cooed and laughed and stuck out her tongue at us in most friendly fashion. Miss Lewis said that one of the interns had made her his especial charge and wheeled her out for an airing every day.

Looking over the report of the superintendent, read before the Woman's Auxiliary in 1915, I found so many good things that I am going to take some of them and give them to you in this article just as they are.

"A patient now keeps his identity. It means that every patient has individual attention, from the doctor down to the humblest servant in the house; that an interest is taken in his mental and physical welfare. In just so far as this interest increases, and sympathetic attention given promptly and cheerfully, will the name 'hospital' come to mean a place of comfort given and not a place of fear."

Miss Lewis, in the same report, gives credit to each of her assistants who has helped to make the hospital a success. She refers to Miss B—, the dietitian, as a very efficient little woman, and tells of the well-prepared and well-cooked food. Elsewhere she mentions the splendid work in the operating rooms and gives the credit to the supervisors there. She says that her day and night supervisors are towers of strength and energy. This sounds like team-work, and you feel it in the atmosphere when you are in the hospital.

The eight-hour day has been worked out successfully here, and is one of the things that has helped to produce the team-work and the cheerfulness. This system is surely an answer to a lot of problems. When it comes into all the hospitals to stay, sore feet and aching backs, some of the apparent stupidity in class work, sick nurses and cranky nurses will all pass. The temper of hospital workers will then begin to be what it ought to be, and administrators and doctors who are willing to work a gentle woman of delicate nervous organism twice the length of time each day that a street contractor would dare to work a husky laborer, will pass along too.

Miss Lewis, in an article in the Department of Nursing in the January number of this magazine, tells of the plan for the eight-hour system and the advantages it has brought into their work. She is now working out a definite time-saving plan for the systematizing of the work of the night supervisors of which she will tell later.

The efficiency of the nursing service is due, not alone to the excellent system in force, but also to the helpful, kindly, human spirit that inspires the system. No one in Grant Hospital is a mere

cog in the machine; the human element is never lost sight of. "I have broken down every barrier between my nurses and myself; I want them to come to me with their troubles and problems as freely as they would to their own mothers," says Miss Lewis. She believes in preventing the complications which sometimes arise in institutions where young men and women meet in their daily work, not by unnatural repression—by forbidding conversation and social relations—but by recognizing the just claim of these young people to acquaintanceship and social relations under proper conditions. Miss Lewis herself introduces her interns to her nurses; she permits the latter, in their evenings off duty, to accept from these young men invitations sanctioned by her, provided reasonable hours are kept. This has not increased the social demands made on the nurses—rather the contrary—so much sweeter is forbidden fruit! Incidentally, Grant Hospital never has any trouble about getting interns.

Miss Lewis believes that the comparatively mature and experienced woman often makes a better nurse than the young high-school graduate. In fact, she prefers, as candidates for her training school, women who have had experience in other lines of work, such as teaching or business, even though some of these may not have had a high-school education.

Each hospital has some one significant thing about it, and you carry memories of each labeled and indexed by that significant feature. You remember one for its fine social service, another for its beautiful scenic surroundings, another for its cleanliness and order, another for its scientific research work, another for its community spirit and so on.

I think my memory of the Grant Hospital will go down something like this: This hospital is efficient, but in getting efficiency it has not sacrificed the individual. There is a human and personal atmosphere about the place. Staff and office, nurses and interns and employees, all seem to have an interest and a share in the work accomplished. The success of Grant Hospital seems to me to be due to several things: the intelligent administration, of course; the financial support of its benefactors; its adequate building and equipment, and to the forceful personality and kindly spirit of its executive head. In a word, it is a non-institutional hospital.

It was a wise old southern deacon who advised with a chuckle: Keep yo' tempah, son. Doan yo' quarrel with nc angry pusson. A soft ansawah's alus best. Hit's commanded, an' furderno', hit makes 'em maddah'n anything else yo' could say.

FROM THE FIELD EDITORS' NOTE BOOKS

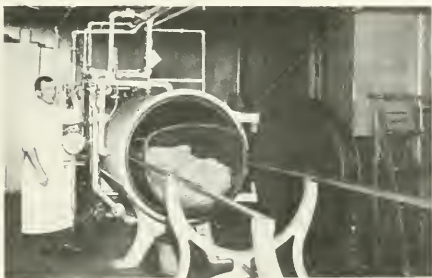
Presbyterian Hospital, St. Luke's Hospital, Grant Hospital, West Suburban Hospital, Evangelical Deaconess' Hospital, Harper Hospital, Agatha Hospital, Sacred Heart Hospital, Youngstown Hospital, and Iroquois Memorial Hospital

Presbyterian Hospital, Chicago

This hospital has taken care of its ward patients without raising rates, although the cost to the hospital of each ward patient is more than seventy-five cents a day in excess of what the patient pays for his care.

When the government requested all hospitals to increase the number of nurses in training up to the limit of capacity, the Presbyterian Hospital went further than this. It fitted up two houses on the same street and removed all the women employees except nurses out of the Sprague Home for Nurses. It then took in probationers to fill every available space left vacant. This move is costing the hospital eight thousand dollars a year.

Unit 13, headed by Dr. Dean Lewis, was largely recruited from this hospital, and with it have gone into service 6 attending physicians, 8 associate physicians, 12 assistant physicians, 15 interns, 25 nurses, 3 orderlies,



Gauze sterilizer used for general sterilization in Presbyterian Hospital, Chicago.

and 9 other employees. Since then the number of those in service has been added to until now the service flag carries under its one big star the number 126.

In the annual report, when one reads down the pages of the medical board, the executive staff, the house staff and the school for nurses, many names are preceded by a little black asterisk and others by a small black dagger. The foot note below reads "In government service." "In Red Cross service in France."

The annual report also contains the following: "Responding to the request of the government for conservation of food, we at once inaugurated a system of serving which has reduced the amount of food used fully 25 percent. This has been done with the cooperation of both patients and employees."

The Presbyterian Hospital is not only doing its bit, but doing its best.

St. Luke's Hospital, Chicago

St. Luke's Hospital, Chicago, has been established for fifty-one years and ranks among the best-known of the high-standard institutions. The bed capacity of the hospital is about four hundred. From seven to eight thousand patients are treated each year. The departments include medical, gynecologic, ophthalmologic, otologic, oral-surgical, dermatological, surgical, obstetric, rhinologic, laryngologic, orthopedic, and neurologic.

Perhaps the most distinctive features of St. Luke's are the high-grade private-room service, the children's department, which is doing especially fine work in orthopedics, and the training school for nurses.

The training school admits only young women who have a definite academic educational foundation for nursing education. This nursing education is given thoroughly and with every means for instruction and equipment. The health and comfort of the nurses and their recreation are carefully provided for. The nurses in the school have the advantage of gymnasium and tennis courts and the privilege of one of Chicago's exclusive bathing beaches. Classes in French are given for those who wish to attend them. Only nurses of the best grade are sent into the nursing field as graduates of St. Luke's.

The hospital, believing it to be a duty to comply with the request of the government to increase the number of nurses in the school, has added twenty-five to the usual number in training. This was made possible by renting two flats in the neighborhood and by the generosity of Mr. and Mrs. W. G. Hibbard of Chicago, who turned over their residence to the hospital for use in housing the extra nurses.

The visitors' dining room in the hospital is an especial feature at St. Luke's. It is not a small room, casually furnished for this purpose, but a large well-furnished dining room in constant use by relatives and friends of private patients and staff.

In the children's department there is a special ward for tonsil and adenoid cases, an entrance observation ward, wards for medical, surgical, and orthopedic cases. There is a kindergarten, and a teacher comes every morning to instruct the children who can come to the classroom. There are plenty of small wheeled chairs for the small folks, and in the children's department every meal for the children who are up and about becomes a tea party. Many a child who would otherwise have little appetite enjoys his dinner when served to him while he sits in a little red kindergarten chair at a low table and with all the other children around it, making a playtime of the meal hour.

The orthopedic department does the follow-up work of the infantile paralysis cases of Cook County Hospital, and the hospital is planning to do the reconstruction work for its disabled patients.

West Suburban Hospital, Oak Park, Ill.

The West Suburban Hospital in Oak Park is a successful open-door hospital of 125 beds owned by a body of physicians and surgeons of that suburb. The hospital has surgical, medical and obstetrical service. It takes care of forty-five obstetrical cases a month on an average. Besides the regular officers of the hospital and the training school, the hospital employs four interns, a pharmacist, a dietitian, and technicians in the pathological and radiographic laboratories.

Mr. Joseph Purvis, the superintendent, believes in women interns for general hospitals. One of the four interns now employed is a woman, and more will be added as needed. The management makes special effort to receive patients and visitors intelligently and cordially, and no discourtesy is tolerated from any employee.



Fig. 1. Grant Hospital, Columbus, Ohio.

In the obstetrical department, opposite the maternity room, is a special room for waiting cases. The patients are brought to this room after the first symptoms of beginning labor, and before it is necessary to bring them to the maternity room. The patient is not returned to her ward or room until she is in good condition, and the other patients in this department are spared the sound and knowledge of the progress of a case in labor.

features of many private hospitals, where the service to the patient and the education of interns and nurses are sacrificed to the making of dividends, are absent in this hospital. The building is always full to capacity, and the proof of public confidence lies in the fact that the hospital has not enough beds to meet the demand for them.

The roof garden, shown in the illustration, is one of the most popular places in the hospital, and patients are



Fig. 2. The roof garden, Grant Hospital, Columbus, Ohio. Here are cool breezes and a wonderful birdseye view of the city.

Grant Hospital, Columbus, Ohio

Grant Hospital, Columbus, Ohio, a private hospital, owned and controlled by Dr. J. F. Baldwin, has 529 beds, a high-grade training school, and all the usual atmosphere of a general hospital. The greater part of its service is given in moderate-priced private rooms. The objectionable

anxious to rest here whenever their condition and the weather allows. A more detailed account of the work of Grant Hospital will be given later in these pages. A paper on "Hospital Housekeeping," by Miss Mary A. Jamison, superintendent of Grant Hospital, appears in this issue.

Evangelical Deaconess Hospital, Marshalltown, Iowa

In the Evangelical Deaconess Hospital in Marshalltown, one sees a well-ordered and cleanly institution which is progressing rapidly and has shown its success by meeting its growing needs. The original building has been reconstructed to add modern hospital facilities and in the near future the hospital expects to add laboratories which will



Evangelical Deaconess Home and Hospital, Marshalltown, Iowa.

give to its patients every advantage of scientific diagnosis.

The new wing of private rooms has everything to make it attractive. The rooms all open on a sun corridor which is surrounded by thoroughly screened French windows. The whole corridor is a sun parlor for convalescent patients.

The Rev. Karl Rest, the superintendent, and Sister Sophie Hublie, the superintendent of nurses, deserve much credit for the advance the hospital is making.

Harper Hospital, Detroit, Mich.

Harper Hospital is surely doing its share. It has sent overseas to France its own base hospital unit, even at the expense of making a shortage everywhere in the organization, in the visiting staff, the house staff, and the training school. The house staff, which usually has thirty interns, now has only seventeen. The hospital service flag carries 119 stars on it.

The second floor of the Buhl Memorial Building, the clinical dispensary building, has been given over entirely to the use of the medical reserve, the aviation corps, and the ordnance department, for physical examinations. Over 450 men have been examined here for the ordnance department. Examinations are also made here for the regiment of expert mechanics and workmen being raised for the government.

Special arrangements have been made for the quarantine of venereal diseases under the new application of the laws controlling communicable diseases in Michigan which the state board of health has applied for the protection of the men in cantonments. Follow-up work is done in these cases and reports made to the state. The emergency war fund of this state is helping to pay the expense of this work.

The chef at Harper has made his own particular recipe for war bread, which the hospital will give to other hospitals who may wish to know about it.

Agatha Hospital, Clinton, Iowa

The Agatha Hospital in Clinton, Iowa, is another hospital which is an example of the good work which can be done in small cities. The hospital has gained the support of the public and will have to enlarge upon its present quarters to accommodate the patients who wish to enter it for treatment.

There is an excellent training school in charge of the superintendent, Miss Tanner, who is a graduate of the Michigan University Hospital at Ann Arbor, and her assistants, who are graduates of the Michael Reese and Wesley Hospitals, Chicago.

The hospital has well-equipped pathological and x-ray laboratories, and unusually good surgical technic in its operating and obstetrical departments. It is fortunate in having on its staff of physicians and surgeons men who use the most modern methods of diagnosis.

The nurses' home has a home atmosphere that is not usual in institutions, and I was particularly impressed with the type of nurses, a type that showed distinctly their culture and refinement and an intense interest in the work to be done. Clinton is certainly to be congratulated in having such a standard hospital and such a thoroughly capable woman to administer it.

Sacred Heart Hospital, Fort Madison, Iowa

The sister superior of this hospital designed herself the chart racks which are used on the nurses' desks on each corridor of the hospital. They are made of varnished wood, and on the inside are strips of zinc which act as slides for each chart. On the outside, on the left of each open space, is a small round brass number plate for each room and ward and on the right of each space, open metal plates in which the names of patients can be easily placed. These racks cost very little and have proved very satisfactory.

Youngstown Hospital, Youngstown, Ohio

The Youngstown Hospital, of which Mr. Fred S. Bunn is superintendent, has a young but healthy offspring in the form of an evening pay clinic for venereal diseases, which is held once a week. It is being displayed with considerable pride by Miss Lucy C. Catlin, the hospital's social worker. It was born on January 21, out of the throes of a desperate need for some means of taking care of the hospital patients having venereal diseases. Note its steady growth. In January it had 11 patients; in February, 27; in March, 35; and in April, 44. Its total collections up to that date were \$265.85; its total expenditures \$229.65, leaving a balance on May 1 of \$36.20. All venereal disease cases are referred to this clinic from the day clinic; consequently some free cases are treated in the evening. Nevertheless, it is more than meeting expenses. While this clinic is considered part of the dispensary work, the accounts and money are kept entirely separate, so that the hospital may ascertain how nearly self-supporting it is. The experience of the Youngstown Hospital Association in beginning its evening pay clinics should encourage other hospitals to start similar clinics.

Iroquois Memorial Hospital, Chicago

Reports from Chicago's first municipal venereal clinic, which was started on January 7 of this year at the Iroquois Memorial Hospital, show results of the most satisfactory and encouraging character. These results, according to the commissioner of health of Chicago, are in large measure due to the helpful cooperation given by physicians and institutions of the city interested in venereal prophylaxis.

The clinics are held daily from 6 p. m. to 8 p. m. Tuesday is reserved exclusively for women. Advice and information are given to all and free treatment to those unable to pay.

Few things are harder to put up with than the annoyance of a good example.—Mark Twain.



The
MODERN HOSPITAL

Editorial Office Conway Building, Chicago
Business Office Metropolitan Building, St. Louis

EDITORS.

Henry M. Hurd Fidelity Building, Baltimore
Frederic A. Washburn Mass. General Hospital, Boston
Winford H. Smith Johns Hopkins Hospital, Baltimore
S. S. Guldwater Mt. Sinai Hospital, New York
W. L. Babcock Grace Hospital, Detroit
John A. Hornsby Conway Building, Chicago

SUBSCRIPTION.

Domestic postage, \$3.00. Foreign postage, \$3.50 (15 Shillings). Single copies, 35 cents.

Domestic rates include United States, Cuba, Mexico, Porto Rico, Canal Zone, Hawaii, and Philippines.

Contributors, subscribers, and readers will find important information on advertising page 42.

Hospital Disintegration or Hospital Conservation —Which?

The civil hospitals of the country are being gripped by destructive forces. The tendency to disintegration, hardly perceptible in the first months of the war, is now rapidly gaining momentum. It is clearly the duty of those who are conscious of this tendency to examine its causes and, if possible without injury to the military power of the nation, to oppose it.

An effective medical staff is indispensable to the success of the army. Behind the army stand the medical and nursing corps; behind these, the medical and nursing professions; and behind these, the hospitals in which doctors and nurses must be trained. There is sound military reason, then, for asking that steps should be taken to maintain hospital efficiency throughout the war.

The appointment of a national food administrator is the executive expression of the doctrine that "food will win the war." Without developing and making effective use of adequate transportation facilities, we cannot win the war, and the President has therefore appointed a director general of railroads. We are told that fuel is another essential factor, and in keeping with this idea we find that a fuel administrator has been on the job for many months. Without a rapid ex-

tension of various war industries we cannot win the war, and a war industries board is correspondingly busy. In the last analysis it is men who will win the war, but a health administrator, to insure a sufficient supply of healthy men, has not yet appeared on the scene. Congress has conferred upon the President the power to act. Is it conceivable that he will fail to do so?

I shall not attempt to indicate all that a health administrator might do to add to the efficiency of the nation in war. I wish, however, to enumerate a few of the talks that would immediately commend themselves to the consideration of a wise national health administrator, in the hospital field alone:

To standardize hospital staffs in order that every hospital might retain in its service the actual number of men required for the care of its patients, and no more.

To complete the organization of the volunteer medical service corps, and to prepare to use the members of the corps to fill dangerous gaps in the service of hospitals, dispensaries, and civilian communities.

The formulation of a plan for the joint use of specialists by civil hospitals and by the military hospitals which are being established to care for returned soldiers. (Australia is profiting by a part-time arrangement; why should not America?)

To find the means, both men and money, by which dispensaries can be kept going.

To arrange for the training of a sufficient number of medical students to keep up the supply of graduates needed by the army and the civil population. (The schools are now graduating about three thousand men annually. Inasmuch as there are nearly one hundred and fifty thousand practicing physicians in the country, and since the average professional life of a physician is about thirty years, it will take nearly five thousand graduates per annum to maintain the existing ratio between the population and the profession, without making any allowance for the growth of population.)

To provide interns for the hospitals which have none at present.

To invite the Medical Department of the Army to reconsider its assumption that a single year of clinical training is ample.

To prevent the further breaking up of the teaching staffs of nursing schools.

To take steps to create an adequate supply of pupil nurses. (According to the survey of the American Nurses' Association made during the period September, 1917, and March, 1918, Massachusetts, with places for 860 probationers, enrolled in the fall of 1917 only 509; Connecticut, with places for 522, enrolled 205; New York, with places for 3,349, enrolled 1,761; Indiana, with places for 529, enrolled 210; Minnesota, with places for 860, enrolled 509; Texas, with places for 1,200, enrolled 226.)

To promote a uniform system of legislation for the training of bedside attendants.

To arrange with the civil hospitals for the training of a large reserve supply of volunteer war nursing aids.

To discover a means whereby hospitals can successfully compete in the labor market against inflated war industries.

To see to it that the government does not unnecessarily hoard medical and surgical supplies to such an extent that

civil hospitals are left without surgical instruments, surgical dressings, anesthetics, and medicines. (The justice of providing for our soldiers first is conceded; but the necessity of laying by supplies equivalent to ten times the estimated consumption of the current year is questionable.)

To urge the government, in framing war tax legislation, to stimulate rather than to discourage donations and bequests to hospitals.

To come to the relief of communities which, as a result of the war, are left without adequate medical and nursing service.

It is only by facing these problems now and by finding a speedy solution of them that the impairment of hospital efficiency can be avoided. Hospital efficiency must be maintained, because the efficiency of the medical and nursing professions is dependent on it and on these, in turn, depend to an appreciable extent, the vitality of the nation and its effectiveness in war.

S. S. GOLDWATER, M.D.

Mobilization of the Civil Hospitals and Allied Institutions for National Service

To win the war and to repair the havoc made by the war must from now on be the chief end of existence for everyone. This means you and me as well as other folks; it means hospitals as well as other institutions. In order to justify their existence, the hospitals must do more than meet the demands of their own self-interest—more than meet the standards of organization and administration.

The civil hospitals have their part—and a very important part—to play in winning the war. It is true that many of them have already made great sacrifices. Some have sent the best part of their medical, nursing, and even their domestic personnel into army service. What more can they do, besides making the best of the hardships which the war inflicts on all of us? A great deal, and in particular three most important—nay, indispensable—things.

In the first place, the hospital is the workshop of the physician and the school of the nurse, and these two, the physician and the nurse, stand closer than the men and women of any other professions to the soldier in the trenches. The hospitals must train nurses, and more nurses, and then more nurses. They must replace medical men and male employees by women wherever possible. Wherever the services of attendants and volunteer workers can with safety be employed, they should be utilized to release interns and nurses. Graduate nurses, moreover, should not be encouraged to remain on hospital cases which could safely be placed on general care.

In the second place, hospitals, by giving efficient

civilian relief, can do much to sustain the morale of our armies. Experience in the armies of our allies has shown that the one thing which is most disastrous to the morale of the fighting man is the worry concerning the welfare of his family at home, and that no greater help to his courage can be given than the assurance that those he has left behind will be cared for when the need arises. The military authorities tell us that a definite system of civilian relief which will provide hospital care for the families of soldiers will be of immeasurable value in maintaining the courage of our men in the army and navy.

In the third place, the hospitals can render efficient service by cooperating with the army medical examining boards. Many hospitals are giving splendid assistance to the medical examining boards. Others are considering first their own convenience and, in consequence, examining boards in many places are seriously handicapped in the work by a lack of proper quarters and equipment. The men on these boards are giving of their valuable time and experience and deserve the support of the hospitals. This, too, is a part of national service. It is an important part of the war machinery and should be assisted by the hospitals wherever possible.

To sum up: What can the civil hospitals do to help win the war? Train nurses—more, and then more nurses. Release those in the hospital who are needed for service elsewhere. Give civilian relief. Assist the medical examining boards. These are the things that the civil hospitals can do now.

Some Practical Papers

A number of especially timely and practical articles on everyday hospital problems are published in this issue, and more are soon to follow. Among those appearing this month are the paper by Miss Mary A. Jamison, superintendent of Grant Hospital, Columbus, Ohio, on "Hospital House-keeping," in which she describes the housekeeping methods which she has found effective in her excellent hospital; that by Miss Nell Shilt, supervisor of surgical supplies at Lakeside Hospital, Cleveland, on the subject, just now of such special importance, of washing used surgical dressings; that by Dr. Malcolm T. MacEachern, superintendent of Vancouver General Hospital, Vancouver, B. C., on "Conservation of Drugs and Other Supplies"; that by Mr. Pliny O. Clark, superintendent of Ohio Valley General Hospital, Wheeling, W. Va., on "Hospitalism—Its Causes and Treatment"; and that by Mr. Joseph Geffen, superintendent of Mount Sinai Hospital, Philadelphia, Penn., on the

often vexing problem of "Visitors and Visiting in Hospitals." A very practical discussion of the subject of "The Standardization of Hospitals for the Insane" is furnished by Dr. William C. Sandy, assistant superintendent of the Connecticut Hospital for the Insane at Middletown. Dr. Sandy, it may be remembered, made for the National Committee for Mental Hygiene a survey of Pennsylvania county asylums, the results of which were published last year.

Two papers soon to be published on important problems arising out of war conditions are one on "The Trained Attendant," by Miss Florence Dakin, superintendent of the Middletown Hospital, Middletown, Ohio, and one on "The Night Pay Clinic," by Dr. A. R. Warner, superintendent of Lakeside Hospital, Cleveland.

Miss Dakin discusses the crisis in the nursing situation produced by the urgent call for trained nurses for the national service. She suggests that many of the difficulties arising out of the present situation may be obviated by establishing training schools for attendants in the small general hospitals of from fifteen to fifty beds. The attendant should receive a certificate only—not a diploma—at the end of the prescribed course, and should not be permitted to represent herself as a trained nurse. This solution of the problem will be viewed with misgiving by many hospital authorities, but this exposition of the plan, by the superintendent of a hospital in which it has been put into successful operation, is worth a careful reading.

Dr. Warner describes another innovation which would doubtless have been vigorously opposed not long ago. War conditions, however, are demonstrating the absolute necessity of some provision for meeting the needs of the self-respecting workingman, who cannot afford to pay specialists' fees, yet shrinks from becoming an object of charity. Dr. Warner shows that the night pay clinic does not compete with the general practitioner—or, for that matter with the specialist—because the work done by the clinic would otherwise either not be done at all, or would be done for nothing or at a loss. On the other hand, the night pay clinic physician receives a remuneration for his work which is not only fair, but well above that received by the average physician in private practice. As Dr. Warner says, "the exigencies of war may in the near future compel the establishment in many communities of organized practice of medicine to provide medical care not only for the workingman but for all the civilian population." He adds that the pay clinic seems especially well adapted to the small hospital. We feel justified,

therefore, in commending this article when it appears, to the serious attention of our readers.

Another very timely and practical paper to appear soon is one by Miss Caroline L. Butterfield, superintendent of Martin's Ferry Hospital, Martin's Ferry, Ohio, on the solution of the house-keeping problems of a small hospital in an industrial community where wages have risen to an almost prohibitive point. Miss Butterfield's ingenious methods of meeting the difficulty by the use of labor-saving mechanical devices, etc., will be of much general interest.

Other practical papers scheduled for the future include one by Miss Mary E. Lewis, whose exceptional work at Grant Hospital, Chicago, is described by Miss Robinson in this issue, on ways of conserving the energies of the night superintendent; one by Mr. Charles T. Hoblit, farm, garden, and dairy consultant to the Illinois Department of Public Welfare, on the work of the farm, garden, and dairy consultant to the institutions; and one by Dr. H. E. Tuley, superintendent of the Louisville City Hospital, on the way in which a large number of administrative problems have been satisfactorily solved in that institution.

In this connection, a number of interesting papers on increasing the usefulness of the hospital records, the library, and the annual report should be mentioned, but limitations of space forbid for the present. We shall have more to say about the articles on these and other subjects a little later.

More Laboratory Technicians Needed

The need for laboratory technicians has grown with the need for laboratories. Time was when a physician guessed at a diagnosis or the need for surgical interference, or did the best that he could to make his diagnosis from symptoms and physical findings alone, but laboratory facilities for diagnosis are as necessary a part of a hospital today as are its operating rooms and its kitchens. Keeping pace with the movement for the standardization of hospitals is the demand for laboratories and for some one to do the work in those already existing, and in those to be installed to meet the requirements for classification. Hospitals in all parts of the country are asking, "Where may we procure a roentgenologist? Where may we procure a pathologist?"

Many medical men who were doing the laboratory work for their hospitals are now in service. Interns are at a premium. Many of the large hospitals which usually have a large number on their resident staff now have very few, and many of the smaller institutions which have one or two under

ordinary conditions now have none at all. Even in normal times previous to the war it is doubtful whether the number of trained laboratory workers, medical men, interns, or technicians kept pace with the increasing demand for laboratories. The present need is emphasized by the announcement from the Surgeon-General of the Army that one hundred women bacteriologists are needed to take the place of men in the cantonment laboratories. This shortage of technical workers may last for some time to come, and it seems that unless some special effort is made to fill the ranks, it may become impossible to utilize this important factor in the adequate diagnosis of disease and the good service to our patients in places where good work had already begun.

This work has really become a specialty in itself, not necessarily attached to the profession of medicine or the degree of bachelor of science. Yet comparatively few of the educational centers are offering laboratory courses which will especially fit the student for work in the hospital laboratory, and still fewer offer special courses available for the training of technicians.

The larger hospitals, which have complete laboratories and teaching facilities connected with training schools for nurses, could give, during the senior year, a definite short course in laboratory work, and after graduation this could be continued as a special post-graduate course by those who had proved their adaptability and their desire to enter the field. The Catholic Hospital Association plans to give courses to the sisters in hospital service during the summer months. If other agencies and teaching hospitals meet this problem as fairly the need will soon be supplied.

The field seems to be one in which women have proved their usefulness. Numbers of graduate nurses have made good laboratory technicians, and if sufficient educational advantages are offered to them to enter upon this special training, they will in time fill the gaps in the ranks.

Compulsory Universal Service—A Ministry of Health

A rather noteworthy "Plea for Universal Service," by Edred M. Corner, F. R. C. S., surgeon to St. Thomas's Hospital, London, appears in a recent number of the *Lancet*. Because it carries even further certain suggestions made in these columns some months ago, as well as because it presents briefly some very important considerations which the nations will have to ponder at the end of this war, we call attention to it here.

The examination of British recruits under Lord

Derby's scheme, we are told, almost invariably disclosed physical deficiencies of weight or height or inefficiency due to disease. Under our industrial system, youths reach maturity blemished by disease; men grow aged when they should be in their prime. In many vocations, as we on this side of the water know too well, in his fortieth year a worker is reckoned an old man. Why is this?

"The core of the matter is," says Mr. Corner, "that men in the working masses wear out earlier than in other classes, not because they are worse men, but mainly because they have no break in their work, no rest, no change, from the day they leave school to take up a trade till the day they cease working for good and all. This tends, perhaps more than anything else, to narrowness of sympathy and bitterness of heart. Can one feel surprised at the unfairness and deep hates of industrial troubles? This unrest is a very real and great social danger which can be largely averted."

Physical culture—compulsory physical culture—is the remedy, in Mr. Corner's opinion. It will not do to leave such a vital matter at the option of the individual. Like vaccination and education, such physical culture must be compulsory and universal, nor can it be allowed to stop with the school child. "There is only one method that I know of rejuvenizing and morally cleansing the nation—universal service, a system of drill and physical culture for men and women. Do not let it be termed conscription—that is a contentious word—but universal service, which, by improving the individual, preventing his aging, increasing his health, power, and ability, adds to his value to his family, his polity, and his nation—that is what is meant. . . . It would be wrong to claim that universal service would rid us of the whole of this great secular and industrial evil; but to say that it would help to diminish it is only the truth. It would be an immensely great economic gain to all."

Team-work, Mr. Corner goes on to say, is the greatest educator of the human race that exists. Commerce allows the individual to work for himself alone and thereby may induce national decay. War, destructive as it is, encourages teamwork and may thus tend to cure the dry-rot of individual selfishness. Yet this destructive remedy may be worse than the disease. In universal service alone may be found the combination of constructive effort and team-work necessary for national well-being. "Not war but universal service is the cure for national ill health." Corner, in short, has rediscovered James' "moral substitute for war." Nor is he the first since James to have made such a suggestion; but the world has

listened with amused tolerance to all such "visionary dreams" of philosophers and humanitarians and has turned away from them to the "practical business" of things as they are—as they were!

As they were—and never shall be again! Make no mistake; never was there a more unpractical world than that which has broken down in the deadliest and most gigantic of all fiascoes of history. Hereafter statesmen and "practical people" will perhaps regard with less foolish scorn and shipshod, unthinking, misnamed conservatism, all proposals for social betterment. We venture to predict that something similar to "universal compulsory service" is going to receive serious consideration in the reconstruction of the world after the war.

Need for Hospital Executives in Red Cross Work

We ventured the prediction some time ago that the day of opportunity for the progressive superintendent was not far away. This day of opportunity is already here; the only question seems to be as to the number of executives who are prepared to take advantage of it. The demand still continues for superintendents capable of taking charge of Red Cross hospitals in France and of government hospitals here and abroad. We have had of late a number of requests, which we have been unable to supply, for the names of candidates for such positions. We would suggest that any superintendent desirous of undertaking government or Red Cross work send to this office, inclosing a stamped addressed envelope, for a blank form which, when filled out and returned to this office, will be placed on file for reference in connection with applications for executives in such work.

Some Last Minute Confidences

An unexpected influx of important and timely matter for several of our departments has made it necessary to reduce somewhat the number of leading articles this month. It has been necessary, in particular, to postpone until August the initial instalment of the series of articles on "Hospital Accounting," by Charles A. Porter and Herbert K. Carter. By way of compensation, some exceedingly interesting and valuable articles are presented under departmental headings. The Bulletin of the American Hospital Association contains a rather full report of the conference held under the auspices of the war service committee of the American Hospital Association, on subjects of vital importance to hospitals under war conditions. We wish also to call special attention to the article in the same department on "The War and Interns in Special Hospitals." This should be taken to heart as a message from the Surgeon-General's Department to all concerned, whether members of the American Hospital Association or not. In fact, everything in this month's Bulletin of the American Hospital Association should be widely read by

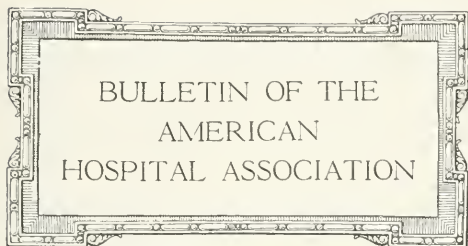
members and non-members alike. In connection with the reports of several interesting association meetings which appear this month, there is room here only to say that the keynote of most of the important meetings is the subject of the reconstruction, rehabilitation, and reeducation of the handicapped, whether from war, from accident, or from disease. In view of the growing importance of the subject, these meetings have a very vital and general interest.

Hot Tea for the Men in the Trenches

"In addition to hot meals which are carried to the soldiers in the trenches," says Maj. George de Tarnowsky, writing in the *Review of Surgery and Medicine*, "the Medical Corps now sends hot tea, flavored with a small amount of brandy, to the front lines twice daily—a most welcome potion, which the soldiers look forward to with eagerness. The prevailing idea of the French Medical Corps is to make the fighting men feel and know that their comfort is being looked after and that everything is being done to mitigate the hardships under which they live. The French are strong believers in the personal element—the little acts of kindness, even of tenderness, towards the individual soldier which have helped to keep up both his fighting spirit and his mental serenity. The 'tisanerics,' as the hot tea stations are called, did not come into existence as the result of army orders; they represent a voluntary contribution to the soldier on the part of the Medical Corps. Begun in a small way, it was soon noticed that, where the tisanerics existed and the regimental kitchens were installed near enough to the trenches so that the food reached the soldier hot, the morale and fighting edge were of the finest."

An appropriation has been secured for the initial unit of the new building for the University Hospital at Ann Arbor, Mich. The capacity of the present building is 400; that of the new building will be 1,000. It will be exclusively a teaching hospital. There is at present a daily waiting list of 50, the patients coming not merely from the vicinity of Ann Arbor, but from all over the Middle West, thus showing that it is not necessary that a teaching hospital be located in a large city.

Dr. Noboru Ishida, author of the article on "The Non-Restraint System in the Insane Wards of Nagasaki Hospital," published last month, was elected an honorary member of the American Medico-Psychological Association at its recent meeting in Chicago. Dr. Ishida intends to establish communication between the American Medico-Psychological Association and the similar society existing in Japan. Readers of Dr. Ishida's article in *THE MODERN HOSPITAL* will be interested to know that Dr. Ishida is the author of the most popular text-book on psychiatry used in Japan, which has gone through seven editions and is about to be issued in an eighth edition. Dr. Ishida says that his advanced ideas in regard to non-restraint of insane patients were at first much opposed by government officials, whose respect for precedent caused them to throw many obstacles in his way. He now finds no difficulty in extending the application of the non-restraint principle. The two features of American psychiatric hospitals which particularly impress themselves on Dr. Ishida are their great size and complete equipment and the sympathetic understanding of the insane shown in their treatment.



Monthly Bulletin issued from the Executive Offices
718 Seventeenth Street, N. W., Washington, D. C.
WILLIAM H. WALSH, M. D., Secretary.

WAR SERVICE COMMITTEE CONFERENCE

Important Discussion of Hospital Problems Arising Out of the War

A conference on hospital problems resulting from the war, held under the auspices of the War Service Committee of the American Hospital Association, met at the New York Academy of Medicine, June 3, the chairman, Dr. S. S. Goldwater, presiding. Others who were present were:

Mr. Richard P. Borden, War Service Committee, Dr. John W. Brannan, Bellevue and Allied Hospitals, Dr. Samuel A. Brown, dean, University and Bellevue Hospital Medical College, Mr. F. S. Bunn, president, Ohio Hospital Association, Dr. Henry A. Christiax, Peter Bent Brigham Hospital (Harvard Medical School), Dr. Pliny O. Clark, secretary, West Virginia Hospital Association, Miss S. Lillian Clayton, president, League of Nursing Education, Miss M. H. Combs, Hospital Social Service Conference, Lieut.-Col. C. H. Connor, M.C., assistant director general, Department of Military Relief, American Red Cross, Dr. E. R. Crew, secretary, Ohio Hospital Association, Hon. Augustus S. Downing, assistant commissioner of education, New York State, Miss Susan C. Francis, American Red Cross, Philadelphia, Mr. Charles B. Grimshaw, Roosevelt Hospital, Maj. John A. Hartwell, M.R.C., Cornell Medical College, Lieut.-Col. John A. Hornsby, representing Surgeon General Gorgas, Dr. Thomas Howell, president, Hospital Conference of the City of New York, Dr. Joseph Howland, Boston Hospital Committee, Dr. O. V. Huffman, dean, Long Island College Hospital, Dr. C. H. Lavinder, representing Surgeon-General Blue, Dr. E. H. Lewinski-Corwin, Public Health Committee, New York Academy of Medicine, Prof. James P. Munroe, Federal Board for Vocational Education, Mr. James Norris, Presbyterian Hospital, Dr. G. W. Olson, president, Minnesota Hospital Association, Dr. Henry Page, Philadelphia Hospital Committee, Dr. R. M. Peters, Providence, R. I., Dr. Renwick R. Ross, Buffalo Hospital Committee, Dr. Alice Seabrook, Philadelphia Hospital Committee, Dr. Ralph B. Seem, Baltimore Hospital Committee, Dr. Alfred Shipley, Medical Advisory Committee, American Red Cross, Mr. Daniel D. Test, War Service Committee, Dr. A. R. Warner, War Service Committee, Mr. Henry C. Wright, State Charities Aid Association.

The chairman, Dr. S. S. Goldwater, in opening the meeting, expressed his thanks to those who had responded to the call to attend this meeting, which represented the beginning of an important movement in the interest of the civil population and the government. It was the wish of the War Service Committee, in the present or future conferences, to reach some definite conclusion in regard to a long list of pressing problems, which were enumerated in the program as follows:

Medical Service.—Visiting Staff: Extent of military enrollment to date: Proper limitation of future enrollment (standardization of hospital staffs as a preliminary): Volunteer medical service corps (availability for civil population): Possibility of part-time military service (requirements at great ports of debarkation and at reconstruction hospitals).

Dispensary Staff: Can voluntary service be maintained: Will the government or Red Cross aid?

Interns: Withdrawals to date: War-time standards: Commissions and the period of inactive service: Maintaining a graded service: How can the smaller hospitals obtain interns: How can the special hospitals obtain interns?

Medical Students: Keeping up the supply for army purposes: Requirements of civil population.

Nursing Service.—Withdrawal of graduates and supervisors: Supply of pupils (shortage shown by survey of American Nurses' Association): How will the new army training school affect existing schools: Should the three-year course be abandoned? Available registered graduates: How should attendants be used and controlled? Voluntary Aids as an emergency force.

Labor Supply.—Actual shortage of paid workers: Can private hospitals secure labor in the face of competition of government and of war industries? Use of volunteers.

Medical and Surgical Supplies.—Need of stimulating production and regulating distribution: Where will next year's instruments come from?

Income and Expenditures.—Effect of war taxes on donations and bequests: Proposed exemption of legacies from Federal inheritance tax: Can the hospitals make both ends meet during the war: Should Red Cross aid or governmental relief be sought?

New Construction.—Needs of civilian population: Should civil hospitals attempt to build now? Will the government facilitate construction? To what extent can emergency (army and navy) construction be made permanent and of subsequent use to municipalities?

Care of Government Patients.—Army and Navy: Emergent cases: Returned (invalided) soldiers and sailors: Location and capacity of army and navy hospitals: Use of civil hospitals: Compensation to hospital: Compensation to staff.

Federal Vocational Board: Cooperation with civil hospital: Special equipment: Training of teachers in existing hospitals.

War Risk Insurance Bureau: Use of city hospitals for in-patients: Care of out-patients: Compensation.

"There are many topics outlined for discussion and it will probably not be possible to debate all of them exhaustively, but we shall try, at least, to get a clear conception of the character of the crisis we are facing. We have with us this morning representatives of hospital organizations in the principal cities of the country, of medical schools, and of various national committees and departments of the Federal Administration."

Dr. Goldwater then presented a plea for the appointment of a Federal Health Administrator, and indicated the problems that would confront such an official in the field of hospital administration alone.

MR. RICHARD P. BORDEN: There is approaching the possibility of an absolute exhaustion of the supply of medical men for the army. In all the medical journals there appear constantly appeals to medical men to volunteer for the service. In the nature of things, the present supply of medical men in this country can be supplemented only in one way and that is by thorough education of medical students, not only in the medical schools and colleges, but by courses as interns in hospitals.

Early in the year, a study was made by the medical section of the Council of National Defense as to the availability of physicians in the country. That was supplemented by an inquiry by the War Service Committee as to the bed capacity of the hospitals of the country, the number on the visiting staffs, and the status of interns. It has been difficult to compile the returns because conditions vary over the country. One small hospital in a small town had a visiting staff of twenty men; it was an open hospital and all the medical men in the vicinity were on the staff. Other hospitals had very small staffs, differently organized. About 20 percent of the physicians in the country appear to be men of valuable hospital experience, and practically 20 percent of the hospital staffs have already entered the service.

So, at the beginning of the year, it seemed clear that, as far as competent physicians were concerned, nearly all the men who could be used to advantage in government service were already enrolled. There is in the rooms of the Medical Section of the Council of National Defense a chart showing the curve of enrollment of physicians in the army. At the beginning the curve is very high; when the profession was first called upon, men volunteered quickly; since then the curve has been constantly dropping; the last time I saw it the number enrolling monthly was less than three hundred. They tell me the monthly

enrollment should be at least five hundred. The question is how and where these men are to be obtained.

In a questionnaire, hospitals were asked to give opinions, in addition to figures, as to the hospital situation. All the answers were to the effect that the situation regarding interns was very serious. The larger hospitals were managing to keep up their supply of interns fairly well, but in the smaller hospitals the interns had disappeared. Some were using medical students and some women physicians, but even the supply of women physicians was being exhausted.

In the last draft legislation, medical students were exempted from the draft so long as they remained medical students, but interns were not included, though by an arrangement through the surgeon-general's office there was an understanding that interns should be allowed to remain in the service of recognized hospitals for one year, provided the entrance was not postponed too long after the receipt of a diploma. An unofficial intimation was given in the surgeon-general's office that the interns might be allowed to remain in the hospitals longer than one year if circumstances permitted, for they recognized that it was extremely desirable from the point of view of the army that young men should be thoroughly trained before being sent out to treat our soldiers.

Another point is, what would be the situation of an intern in a special hospital, tuberculosis, insane, women, children, etc.? The regulations issued at Washington called for internships in general hospitals exclusively. The War Service Committee took that up with the surgeon-general's office and at an authorized interview it was stated that the probable policy in all our hospitals, except those for women, would be the same recognition as if in a general hospital. Women's hospitals were excepted because the training was not suitable for military purposes; men who are unfit for active service should be induced by the medical schools to seek internships in the women's hospitals, while young men able to perform military duties should avoid them.

Efforts should be made now to conserve the supply and provide for the education of the coming members of the profession; to see that the organization of hospitals is not disrupted; and to make available those men who must remain at home to carry on the work of the medical schools and instruct interns and nurses in the hospitals. It is the duty of a proportion of the best men in the profession to stay at their posts in order, as need increases, that other men will be educated for duty as the war goes on. General Gorgas has said that the cream of the medical profession is now in the army; this was intended as a compliment to the medical profession, but it implies that only the skimmed milk is left to draw upon. Is there wisdom in such a program? As representatives of the American Hospital Association, we recognize the need of the people for hospital service, and we believe that the organization of the civil hospitals should not be disrupted by too free use of the talents necessary to continue those institutions in efficient operation.

DR. BROWN: I think the threatened disorganization is due largely to lack of vision. The remark of the surgeon-general that the cream of the profession is now in the army is a reflection on the stay-at-home physicians. They tell us in one breath that teachers are necessary and must remain at their posts, and next that the cream of the profession is in the army! We ask what is the definite and positive plan for the control of interns; they reply that interns can serve one year; then they say three or four months is sufficient. Only the hospital authorities know whether a man is fit for medical duty at the end of a stated period. Some men require longer hospital service than others. I think there should be some way in which the hospital could say a man was prepared or not prepared to go into the service. Thirty or 40 percent of the interns who have joined the Medical Reserve Corps have not completed a year in hospital.

I think the question of accepting for the Medical Reserve Corps members of the visiting staff of hospitals or colleges should be referred back to the hospital or college for consideration. This would make it possible to release those whose work can be done by others and to keep those whom it is impossible to spare. There should be some recognition of the men who are doing teaching; we shall not be able to hold these men unless their work is recognized.

DR. CHRISTIAN: The problem of the medical schools is where the next year's freshman class is coming from. The only provision I can see is for men in college who have had one or two years of the necessary preliminary training and who are far enough away from 21 to feel that if they start in the medical school they can get a reasonable amount of medical education before they are drafted. But that, probably, is not a large number. A student is likely to say, "There being no assurance that if I start in medicine I can finish, I will go immediately into active, non-medical service."

The remaining service of medical students next year is derived from the physically unfit; of those we shall get a certain number, but not a large number. The government should now decide how many students they wish to have in the medical schools next year and should then provide for them.

There are other problems confronting us. One of them is how to stop the stampede of medical students into active service. When the student is enrolled in the Medical Corps, he is told he can transfer to some other branch on petition. Every now and then a student gets it into his head that he would like to go, for instance, into aviation, and in his enthusiasm he starts a stampede. The government should reduce the number of such transfers.

In regard to the intern year, one plan that might be considered is the inclusion in the four years in medical school of four months of intern service. That may prove to be necessary. It should be recognized, however, that this means less medical school education and less intern preparation; that is, it is not a full medical course or full hospital service, but some medical course and some hospital service. If the government needs men so badly as to be able to use poorly trained ones, that is the way to get them. Otherwise, it is most desirable to continue the full four-year medical course and one-year hospital service.

In Boston, the men have been allowed to complete their full hospital service, but we hear from other cities that men are called to service notwithstanding the fact that they were registered as interns. Such news disquiets medical students; they say they had better get a good commission now rather than start in hospital service and get only the first part of it, which is made up of rather unattractive routine work. If the government is not going to require the twelve-month service, the hospitals should be told so that they can adjust their service. We can attain the required grade of service with the twelve-month time allowance, but if we have only part of the men for twelve months it will be impossible to maintain a graded service.

Owing to the scarcity of medical personnel, we have found it useful in Boston to employ a large number of technicians to do laboratory work. In addition, we are training women. That is an added means of getting around our difficulties; there is an opportunity for the medical schools to help by using their laboratories for the teaching of technicians.

MR. BUNN: We have lost a number of men from Youngstown, and are finding that the use of nurse and anesthetists and technicians in the laboratory is helpful. We are putting in dictaphones for taking histories on account of the diminished intern service. The hospitals in Ohio are laboring under a tremendous disadvantage. There are 7,800 physicians in the state, of whom 1,000 are in the service. Dr. Freeman said last week that the ones taken out were among the most efficient ones; the 7,800 includes many retired, some antiquated, and institutional appointees, so that at least one-sixth of the total number of those actually in practice could be said to have been withdrawn. Ohio's quota of nurses is 3,500, and 1,500 are in service, so that here also we are suffering from shortage. We have only about one-half the number of interns we had before the war.

DR. ROSS: I think the intern service in many hospitals could be simplified. The intern has too much clerical work to do outside of that purely medical. This could be turned over to other employees. Lay people can easily be taught to take histories, write up operations, do laboratory work, etc., and, without lowering very much the standard of hospital work, we can reduce the number of interns by one-third.

DR. SEABROOK: The women have been coming into the work and filling the demand as far as possible, but there

are not enough to go around. We have felt the stress in my hospital. During this last year, instead of eight interns, I have been working with five. This year I expect to have my full quota, but I do not know what next year will do. I think the work, as Dr. Ross suggested, can be so arranged that much can be taken off the intern's shoulders by others.

DR. GOLDWATER: In comparing hospitals with each other we must consider actual conditions. The large hospital may spare a certain proportion of its intern staff. The small hospital needs its own intern badly, and it is precisely the small hospital which is suffering the largest losses. As to visiting staff, there should be some standardization. A hospital with a "continuous" service organization can perhaps spare 20 percent of its attending staff; a hospital with a "rotary" service, where four men during the year, each serving three months, do the work of one, can spare two or three times as many. It is a question whether the rotary service ought not to be abolished during the war.

LIEUT.-COL. HORNSEY: I can, perhaps, tell you some of the things we are talking about in Washington in this connection. I was sent to this meeting, perhaps, because I am more the civilian than the military man, thoroughly in sympathy with the civilian problem. I appreciate the difficulties of the civil population. These difficulties, however, did not start with the war. They existed when it began. The intern question was a perplexing one before that, largely due to the improvement in the standards of preliminary education for medical men, and the resulting elimination of many schools from the medical education.

I have been in the closest touch with the whole country, by reason of my connection with the war hospitals. It is not a new problem for the small hospitals to be embarrassed for interns. The thing that calls for attention is the future; the question is, where will we land? We are making progress, and I think much of that is due to our recognition of the helpfulness of civilians, such as Dr. Goldwater, whose help has been invaluable—even when his advice hurt it was most valuable. The army sometimes may be thought to be arbitrary and self-sufficient, whereas, if the whole story could be told, it would not be found so.

We are doing the best we can with this question of interns. Colonel Arnold is working day and night so that we may be in a position to know everything in regard to the question of distribution, employment, and utilization of the services of newly graduated men. Something will probably be done soon with the question of securing medical students, but I don't think it will be done as Dr. Christian suggests, by commandeering them. We have a lot of enlisted men in the Medical Corps of the army, and it might be found feasible to comb that enlisted personnel of the Medical Corps for men eligible for the medical schools. Many are educated men who, having been given the option of going into one or another branch of the service, have chosen the medical enlisted branch.

As for the increase in the medical forces, fully 10 percent of the active physicians of the country are in uniform at the present time. That means more than 10 percent of the eligible men, men out of practice, and those physically incapacitated. It is true we have taken many of the best men, the most active men, because they have been eligible physically. Up to the present, it has not been felt possible to take a man for some special service, a man ineligible for well-rounded service for overseas work.

It would be desirable, if possible, to make a more adequate distribution of men for military service and take this or that man and leave a number home. But we are unable as yet to do this. The only thing we can do at this time is to accept volunteers except those in the draft age. The draft law is one of the reasons why many young men have gone into the Medical Reserve Corps who would otherwise be loyally and heroically sticking to their posts; it is heroic to stay back when a fight is going on, but the draft law is one reason why many are going into the army.

MR. TEST: They are calling from the house-tops that a man is not patriotic unless he joins the army. It may require a higher grade of patriotism to stay at home than to join the colors. I doubt if the surgeon-general's office is responsible so much as the local recruiting offices. The surgeon-general should let it be known that it is a patriotic duty for some to remain in the civil hospitals.

In reference to interns, I do not think the surgeon-general's office can be censured for taking the men before they have had a year's service. I believe if the hospitals had notified the surgeon-general, these young men would have been allowed to remain. Lately, the surgeon-general has refused to take them before the completion of their year of hospital service.

DR. HOWLAND: They say the Surgeon-General of the Army does not take the interns until they have served a year; but the navy takes them before they have their diplomas. We have one young man who has received his appointment in the navy and he will not be graduated for a day or two.

The idea of lay service to relieve interns of clerical work is a good one. We started that some time ago and have at present come to depend on our technicians.

I think a modification of the requirements for a degree, or even two preliminary years in college would be satisfactory at present. A man who has a high-school education can do well in medical school.

MR. BORDEN: If it can be shown that a man has been taken into the service of the army or the navy before the close of one year in hospital, his appointment will be withdrawn. That has happened in several cases.

DR. GOLDWATER: It is true that at the beginning the navy's policy was to take men right out of the medical schools. The idea was erroneously held that a year in the navy would be equivalent of a year in hospital. The result was that when put on the transports, untrained graduates were found to be totally unprepared or responsible and an effort has since been made to provide for them, while in port, the opportunity to make up some of the hospital training they failed to get in the first place, before being commissioned.

DR. PAGE: This matter will have to be regulated by some centralized authority. Large hospitals in the cities have no difficulty in getting interns. I get appealing letters, however, from managers of hospitals of fairly good size to get them at least one intern for the coming year. We have been working with 50 percent curtailment and the efficiency of the hospital has not greatly decreased. In Philadelphia and through Pennsylvania generally we are in difficulties because by state law we must give an intern some training in every branch of the service. He must have laboratory work, so though we employ technicians we cannot always substitute them. It is feasible to limit the number of interns in any given hospital, but it is unfair for the hospitals not to be able to get adequate intern service when the large hospitals could spare some of their men.

MR. TEST: If some hospitals can spare more men, they should; provision should be made for distributing the surplus where most needed.

DR. GOLDWATER suggested that the situation could only be controlled by a suitable federal authority, and asked the conference to consider the following resolution:

Resolved, That under the direction of a Federal health administrator or other suitable Federal authority, a program should be prepared for maintaining an adequate supply of medical students and of properly trained physicians and nurses during the war; in so far as the extension of the existing facilities for training may become necessary, the means for such extension should be provided by the government. Surveys in nursing and medical fields which have already been undertaken by governmental and private agencies should be extended, coordinated, and completed. A program should be prepared and carried out, in cooperation with the military authorities, for the most effective disposition of students of medicine who are of draft age and for the modification of their training to meet war requirements. Medical institutions, physicians, and nurses should be brought under the direction of the government whenever necessary, to insure adequate attention to the needs of the civilian population.

This resolution was unanimously adopted.

DR. CHRISTIAN: My suggestion in regard to procuring medical students was misunderstood by Colonel Hornsby. There are many young men in the colleges who, under normal condition, would enter the schools this autumn. My idea is that these men should be allowed the opportunity to enlist, between the ages of 17 and 21, or up to the draft age, in the Medical Corps, with the understanding that they would be assigned to a medical school, in the same way the present medical students are working and that on graduation they should be permitted to apply

for and receive commissions in the medical service. The surgeon-general's office should state how many medical students the government thinks should be in the medical schools next year, and should ask for that number of volunteers for enlistment, with the understanding that with that enlistment will go their commissions provided they do good work—that is, they would be commissioned on graduation.

I suggest that a good deal of what we said about technicians is equally applicable to the service of commissioned medical men. Former interns now in the service complain because they are not busy or are treated as "cheap labor," being given chiefly clerical work and laboratory technician's work. Without in any sense decrying its necessity, should such work be done by men who are qualified at great expense to do other and more pressing tasks?

LIEUT.-COLONEL HORNSBY: Many medical officers have been kept around camps and there is a common complaint that some have not enough to do. They do not understand why they have not enough to do when the army is so busy. The men in the camps are not necessarily there because they are of real value, but because they must be trained, and part of their training is in military paper work. This is fundamental knowledge which they will require when in active service. Some men are far from appreciating the fact that they are sent to camp for training and are overlooking opportunities to get that training. They want to practice medicine. The army hopes in the course of a few months to give them a sufficient amount of military training to enable them to practice military medicine. There are questions of insurance, pensions, rights of individual soldiers, questions of coordination, military methods and procedures, and it is necessary that that end of it shall be appreciated by the medical officer.

DR. ROSS: How are we going to get a supply of nurses for our hospitals?

MISS CLAYTON: The nursing profession is having great demands made upon it, and in meeting this need we feel that we should try to look forward to the future as well as to consider the present. At the recent convention in Cleveland we outlined three lines of effort which we believed would help meet the present situation, one of which is a military school of nursing. This army school will help the future of hospitals because there is to be close affiliation between the army and the civil hospitals. You ask if we think the army school will affect the civil hospitals, or reduce the number of their nurses. To some extent, yes. The training schools short of nurses today are short of nurses always. Our best schools have no serious complaint. From those schools we believe we will draw no nurses. Our army school will admit young women between the ages of 21 and 25, with high-school education. There are hospital training schools that accept young women with only two or three years of high school education, younger than 21 and older than 25. We believe the Army School of Nursing to be a good plan. The teaching will be entrusted in part to the medical men in the cantonment hospitals, including some of the best physicians in the country.

DR. GOLDWATER: But the medical personnel at cantonments will constantly be changed. How, then, can they form an effective faculty?

LIEUT.-COLONEL HORNSBY: As we find the men becoming competent to handle their work, they will be sent abroad. The surgeon-general is not likely to continue "faculties" anywhere. I was present at the conference at which the army nursing school was authorized. The Secretary of War said he would approve the idea of putting in two or three of these training schools to start with. If they worked out all right, the general scheme might be approved in toto. If there were any reason why the plan should be changed the reason would soon develop. The army nursing school is not to be considered as a completed plan, approved at once for the whole army. The thought was that there being no immediate need to do otherwise, the Secretary of War was willing to see it tried out. If it develops that there is need for something else, that will be done. It seemed to the secretary that there was no such emergency as would make it impossible to try out this program for a reasonable period, everyone believing it a good one if it will meet the needs of the army. The Secretary of War, therefore, gave the plan his tentative approval, but conditions in the army are changing so

rapidly that any moment may see the necessity for the withdrawal of this approval.

DR. ROSS: As I understand it, the Red Cross has asked for 5,000 nurses from the Atlantic Division this month. They ask for 250 from our city. Yet Colonel Hornsby tells us there is no emergency.

DR. GOLDWATER: A distinction should be made between present and future need, and also between the need of the army and of the Red Cross. The Red Cross has in mind two things, first of all to help the army, and second, to meet its obligations toward our allies, whose need of nurses in both the military and civilian field is great and insistent. At present there are practically no nursing reserves—no enrolled nurses fit and available for immediate duty, to replace the large drafts which the overseas forces are making on the cantonments. This accounts for the urgent call.

LIEUT.-COLONEL CONNOR: I might say that in any enrollment for military service the call is received from the surgeon-general's office. The outside quota, which goes into Red Cross civilian work in France and Italy and, it is contemplated in Russia, is outside of military service. The majority of the nurses the Red Cross is calling for now will be used in the military and naval service.

MISS CLAYTON: We have taken other action as part of the nursing program. We are starting a campaign for nursing attendants. We are appointing committees to look into the needs of the entire community, hospital need, the sick in the homes, and in the public health field. We believe we can use to better advantage the nurses we have in every community. Most applicants for enrollment have come from institutions; many are public health workers or teachers, not nurses who are doing private work among the wealthy. We believe that thousands of nurses in private work can be relieved.

DR. HUFFMAN: Unlike some western schools, we have felt no shortage of medical students. The prospects are that next year's enrollment will be normal. But I feel from my study of the situation and from what I hear that there should be some definite program, in regard to the medical student, on account of the legal preliminary requirements before a medical student enters medical college, which in New York State are so explicit; something will have to be done in a year or two to take care of those who have not met these preliminary educational requirements, and who will be barred from the medical schools either by the draft or because they cannot meet the preliminary requirements.

As far as interns are concerned, it is difficult to foresee what will happen. We have an intern enrolled, and within the space of a few days he has entered the army, or a small hospital has tempted him away with salary.

MR. DOWNING: As far as the conservation of medical students is concerned, there will be no trouble about that. All the slackers who do not want to get into the army are going into the medical schools and without any intention of becoming physicians. They told us from Washington not to speed up our medical schools. We found we could speed up our four years' course. We saw what was happening in spite of Washington saying we need not do it. We foresaw they would take interns from our hospitals and we would need graduates to take their place. The fourth year has been successfully speeded up so that men were made ready for the hospitals in February instead of June.

About the nurses, that is more serious. They are not taking Red Cross nurses out of the training schools; they are taking them from private practice; but with 20,000 enrolled they have only used some—may I ask Dr. Goldwater for the figures?

DR. GOLDWATER: Twenty thousand enrolled, 11,000 to 12,000 in active service. The remaining 8,000 or 9,000 are not available; they are wholly or chiefly made up of superintendents of training schools, assistant superintendents, public health nurses, women rejected on physical grounds, women acting as Red Cross instructors or doing Red Cross committee work, women enrolled for limited home service. There are few available army nursing reserves among them at present. The surgeon-general's office is depending on future enrollments, and appears to be confident that these will be timely and sufficient.

MR. DOWNING: If there are thousands engaged in private practice, if they are needed and there is no other way to get them, they will have to be drafted. We must

also get a body of women together that will take care of the civic sick who are convalescent and do not need a trained nurse, and of the wounded men who are going to come back. Some of them are back now. We must be able to take care of the men that need trained service at once. If the army training school will do it, all right. But it seems to me the scheme to train these young women in cantonments has some serious drawbacks. You can found your training school in a cantonment, but where will you get your supply? Who will go there? How long will it take to train them? They will have a three-year course. They will be fitted as trained nurses at the end of three years. They will be available where? In the cantonments only. There are about forty cantonments, averaging 40,000 men, and 2,000 now sick in each cantonment. Two thousand sick will require 200 nurses. Eight thousand women are needed in these forty cantonments. They will have to be women of the staunchest character. I do not believe that the army training school will meet the emergency as it exists today, nor am I in favor of any short-course training school for training nurses. It is a great temptation to get training in a military hospital; candidates will pass up the civilian hospitals, and you will drain the nurses' schools of suitable material.

We must not lose sight of the fact that we have a civil population to be taken care of. When they take our trained nurses out of the hospitals, we must have a few good ones left as supervisors.

There are thousands of women in this town who want to do something for their country. I say, give them a chance. Here is one who can get away for three hours a day from her home. Take her in the hospital and train her. And when she is fit put her through an examination on the knowledge necessary for taking care of the chronic case of the convalescent. We will get a body of women that will be trained and ready for an emergency.

Some day, pretty soon, instead of short lists of casualties, we shall have two, three, ten thousand American soldiers wounded. The hospitals in France are full now. They are asking for nurses. Many will have to be taken care of here. We do not want to be caught three months hence with no one to take care of them.

We must work out a plan by which the civilian sick and those not badly hurt that just need a little nursing can be cared for by those whom Dr. Goldwater calls "war nursing aids." We can specify certain hospitals in this country as those we will recognize as fit to do this work of training women for nurses' aids. We want help during the war. If there are any young women who want to take this course now and go into nursing afterward, I would give them credit for the work they have done toward the three-year nursing period.

MR. BORDEN: It does not seem to me that the medical profession volunteered in the army for the purpose of teaching nurses, as it is proposed they shall do at these army training schools. If the Medical Reserve Corps are to devote their time to this, they might just as well be allowed to remain in civilian life. Also, if trained nurses must give their time to training these pupil nurses, they should be allowed to do it in civilian hospitals. Who can say how long these cantonment hospitals will be retained for the training of these women? Suppose in one year the war should be over, what will become of these training schools? What promise can the army make to these young women that they will have an opportunity in the existing hospitals to complete their nursing education? If they cannot promise this, they should not accept them. It is only fair that pupils should have some assurance that their training will be completed. Last week, at a meeting of the Ohio Hospital Association, a paper was read by a representative of the surgeon-general's department pupil nurses and war nursing aids so they can be can do very little for the returned soldiers, but they can ment. The final word was this, that the civil hospitals used as required in the service of the government.

DR. HOWLAND: I think the future of these nurses is the least consideration at the present time.

DR. WARNER: Has Miss Clayton any idea what proportion of graduate nurses not in active duty are available for army work? Many graduates have husbands and small children, or physical incapacities; they are unthinkable for even temporary work at home, to say nothing of going abroad.

MISS CLAYTON: I cannot answer that question abso-

lutely. In our locality we consider that one-fourth of all those we consider available for service could lay down the work they are doing and go into military work.

MR. BUNN: Has any thought been given to making use of the senior pupils? We hope to be able to spare one-half or more of our senior nurses, if necessity arises. I would be willing to send one-half to the cantonments and let them care for the soldiers.

DR. SEABROOK: When the call came for nurses our state board of examiners made the suggestion to Washington that they should take the pupil nurses from the three-year schools at the end of two years and they would be eligible to go for war work in army hospitals under supervision and at the end of three years would be eligible for registration and diplomas would be granted.

MISS GREENER: If we are to maintain our home hospitals at standard efficiency, we cannot spare our third-year pupils. In January, when our unit went out, we had 21 enrolled Red Cross nurses; 16 more were about to go out with the unit, which left us only 16 graduate nurses. There are no nurses in the country that can be brought into the hospital to fill such vacancies; the only way to replace graduate head nurses is to use third-year pupils.

We are confronted with another problem about enlarging the schools. We have plenty of applicants, but we cannot get household help to take care of them and we cannot ask them to do the work themselves. We can hardly take care of the group of nurses we have at the present time; so there is no inducement to take on more pupils at present.

LIEUT.-COLONEL HORNSBY: The army does that the secretary will not permit and the army sure do not want to take the pupil nurses in either the second or the third year from the civil hospitals.

AFTERNOON SESSION

DR. GOLDWATER: The hospitals will sooner or later be called upon to treat handicapped soldiers. Relations will doubtless be established with the federal agencies that are to be responsible for the rehabilitation of soldiers and sailors. The vice-chairman of the Federal Vocational Board will now address you.

PROF. MUNKOE: I speak absolutely unofficially as an individual rather than as a member of the vocational board. There is a bill before Congress in which sole responsibility for the soldiers and sailors after discharge from hospital has been placed in the hands of the Board of Vocational Education. This is to be brought up in the House this week, but until that bill is passed the board has nothing to do with this problem.

Nevertheless, the matter has been under discussion so many months that we have made some study of this problem. We have issued two bulletins, the first a study based on former experience of the problem of vocational rehabilitation of retraining the cripple in an old, or training him in a new, vocation after his physical rehabilitation, and second, a study of preliminary vocational therapy. Then we have in press a study of what has been done in the allied countries. In addition, we have sent twenty persons, men and women, specially competent for this kind of work to study Canadian methods.

Furthermore, we have constantly, since early last fall, been in conference with the surgeon-general's office on certain aspects of vocational rehabilitation and the difficulties that will arise in this proposed legislation in cooperative work between laymen like ourselves, dealing with the vocational side of the man's training, and the medical profession dealing with his physical rehabilitation.

The bill states that the surgeon-general's office has full and absolute control over the medical and surgical rehabilitation and absolute military control over the man until, in their opinion, he is fit for discharge from the hospital. Then the Federal Board of Education takes charge of him, in consultation with the War Risk Insurance Bureau. The bill enjoins the surgeon-general's office to call on us in an advisory capacity in the work of bedside occupational therapy with its bearing on the future; and our board is enjoined to call on the surgeon-general's office for subsequent medical and surgical care which the man may require, and on the Bureau of Labor to get the man placed back in industry. We have been in constant communication with the United States Chamber of Commerce and various employers' liability organizations and the American Federation of Labor, our desire being on the one hand not to upset the regular flow of industry and on

the other hand to see that the man is not exploited for the selfish purpose of the industry.

The problem of the cooperation of the surgeon-general's office and our board in the determination of what shall be the bedside occupation before the man is discharged from hospital is going to be a difficult one, and it cannot be solved unless the two sides are willing to cooperate in the friendliest way.

If you are going to reeducate a man vocationally and put him back in society as a working unit, you must begin from the moment he is brought back from the trenches and put him in such a frame of mind that he will not only desire to become an economic unit, but his mind will be filled with the idea that it is his business to get well trained as quickly as possible so he may go back and serve his country from the standpoint of economy as well as he has done from the military standpoint. That is largely a question of psychology—never permitting him to think he is broken, never allowing him to get hospitalized, never permitting him to doubt but that he is just as good a member of society as before his catastrophe. We believe that not only does this require the proper attitude of mind on the part of the medical men and nurses, but that there must also be someone whom we call a "vocational advisor," who is absolutely familiar with all forms of vocations and who has the right attitude of mind regarding the relation of the man toward the vocation; the vocational advisor must have opportunity to come in close contact with the patient and must have cooperation from the physicians and nurses.

The plan would be for the Federal Board of Vocational Education to have the right to put into every hospital where these soldiers and sailors are taken a "vocational advisor," who shall have free access to the medical records, to the man himself, and who shall be in constant consultation and touch with the surgeons and doctors and educational men inside the hospital who are guiding his vocational therapy. These three men, the surgeon in charge, the director of educational therapy looking after the hospital work, and the vocational advisor, these three men before that crippled soldier leaves the hospital, should have made up their minds within what range of occupation the man is fitted. There are four or five hundred occupations. If there should be established within the hospital ten or twelve basic lines of occupation, woodwork, iron, electrical, accounting in the higher education, and a few more things like that, the hospital training can be made very broad and at the same time can contribute the occupational therapy, and when the man gets out of the hospital he will have a broad basis on which the Federal Board of Vocational Education can, with the advice of the doctor and the men in the hospital, decide what special vocation out of 500 possible occupations he can be trained for. That is the line of vocational training which it would seem wise for the hospital to undertake. There will be a temptation in certain hospitals to retain the crippled man beyond the period when he is physically rehabilitated in order to give him the necessary, from their point of view, vocational training. It seems to me this would be unwise. I am considering the ones who never go back to the army but who will be civilians, and the sooner they get out of the military atmosphere into the civil atmosphere the better. The vocational director going into the hospitals should be a civilian, for he will better be able to keep before the crippled soldier the civilian point of view.

There is a possibility we shall learn of wounded men coming back in thousands and tens of thousands and subsequently, unless the surgeon-general's office has matured a plan for sufficient beds, there is danger that many of them will be turned out too soon because their room will be needed. Consequently, it seems to me, there is a possibility that the War Insurance Bureau will be obliged to ask the cooperation of civil hospitals in helping solve this problem of trying, at the same time, to carry on the final physical rehabilitation and also the vocational rehabilitation. If the military hospitals should be subjected to unexpected pressure of men returning in large numbers from the other side and forced to deal too early with this problem, then the question comes up, can the civil hospitals take these men in the borderland period between too early dismissal from army hospitals and the time when they must take up their lives again and get back to industry, complete their physical rehabilitation so we will not have

to take them half cured and try to make proper members of society out of a physically sick man?

DR. HOWLAND: I have been trying to find out just how Boston is likely to be affected. The army has not yet used the civil hospitals to any great extent, though a few cases from the surrounding camps have been sent to us, but the navy found itself inadequate to care for that section and practically all the hospitals have been used to take care of 25, 50, or 100 naval enlisted men. The thing that bothers me is the outlook for taking care of returned soldiers. We are told the surgeon-general's office intends to take care of them in large units in army hospitals, but except for reconstruction hospitals I know of no attempt to start or locate such hospitals in New England. It is a vital question with us when every day some member of the staff says, "May I go now?" What demands will be made of us? We ought to know that so as to know what to do with our staffs. I hope the matter of war risk insurance will be spoken of. As I understand it, there may be enlisted men or officers of any branch, so there are complications.

MR. BORDEN: The question brought forward by Professor Munroe is only one of the problems that have to do with taking care of returned soldiers. The thing to do is to urge that the hospitals receiving returned soldiers should be located as near as possible to the place from which the men originated. The surgeon-general has agreed to this, but up to the present time the declared policy of the surgeon-general's office has not been followed. The present needs of our hospitals from industrial accidents are thirty-eight times what we may anticipate from military ones, so the civil hospitals are interested primarily in the first. The government has taken steps to solve the problem of vocational therapy. It has been recognized that the vocational rehabilitation should be in the line the man followed before he went into the army, and, if possible, in or near the place where he entered the army; the place where he can best put his knowledge and training to use is in his own former neighborhood.

What about these occupational schools after the war? If badly located in remote places, they will be of no use. These schools should be established in big centers of population. The place where occupational schools should be is where the most people can be gathered, where there are all forms of industry established, and where the men can go right into the shops and factories as soon as they are trained.

LIEUT.-COLONEL HORNSBY: I would like to answer Dr. Howland. I am under orders now to go to New England to look over the ground preparatory to the establishment of another hospital in New England. We are now spending money to fix up the buildings at Plattsburg and after the midsummer training camp is vacated it will be fixed up for a zone hospital. I expect to confer with such people as Dr. Howland and with the governor of Massachusetts, who recommended a state appropriation to build a hospital. In other words, we are alive to the necessity of having another hospital in the New England district. One hospital is ready now, and patients have already entered in small numbers.

In regard to vocational training, it has been understood fully that we would need a great deal of cooperation, and I was under the impression that we had all agreed to give it. I believe the surgeon-general's office has been most generous in its attitude toward the opinion of others. We can hardly get closer to the problem by assuming in advance that someone is going to blunder.

May I go into this question of military hospitals? The country has been divided into districts corresponding to the draft districts. In New York, a port of embarkation, we have 8,500 beds authorized already and shall have in a few weeks in New York 11,000, in and about the port. We are ready for that many here. These beds will be, for some time to come, available for distribution. If we get crowded at the port, we shall send the patients back to the draft district from which they came. At Newport News we are doing the same thing. Boston is not slated to be a port of disembarkation, but if it becomes one we shall have to take the matter of hospital beds into consideration there. Philadelphia is in the same boat. I have every belief that the desire of the surgeon-general's office is to get the sick and wounded out of the way. We do not want to be burdened with the care of people who are getting back into civil life. The army should be reserved

for aggressive fighting and the rehabilitation and reconstruction of the sick and wounded who are beyond military service ought to be and will be a civil process in the hands of civilian organizations and managed on civilian principles.

DR. GOLDWATER: A communication sent out by the National Association for the Study and Prevention of Tuberculosis declares that under the requirements of the United States Government all issues of bonds, stock, or other capital required for the erection of new institutions or additions to existing ones must be approved by the capital issues committee of the Federal Reserve Board. The capital issues committee apparently will approve only of the building of temporary wooden or other structures for hospital purposes. They fully appreciate that this is not an economical method in the long run, but for hospitals that must be built now this is the only way that is allowable. The association is preparing a set of designs for tuberculosis hospitals to conform with this ruling. What are the general hospitals proposing to do about necessary building?

DR. ROSS: Since our country declared war, we have spent over \$400,000 in building, nearly \$500,000. We are expecting to start another building within three weeks. The difference in cost of construction between the contract in the fall of 1916 and one contract made last May was only 1½ cents per cubic foot. The contractors claim it is just as advantageous now to construct buildings as it has been for some time past and they have no idea that construction is going to be cheaper. I can see no reason, if those statements are true, why construction should not go on at the present time. Plumbers, steamfitters, carpenters, etc., are easy to obtain because building has largely been shut off throughout the country. Only common labor is in great demand. All our buildings are reinforced concrete instead of steel; it makes just as good a building and the cost is considerably less than the steel.

MR. TEST: So far as Philadelphia is concerned, hospital construction is almost at a standstill because of the present high cost of construction.

DR. GOLDWATER: To maintain existing hospitals renewals are required. In order to maintain for the use of the country at large the existing 800,000 beds, we must have new construction at the rate of 20,000 to 25,000 beds per annum, and provision should be made for such construction if materials can be obtained.

DR. OLSON: In our state there is some hospital construction going on. In Minneapolis there is a new building being opened, a Catholic hospital, which will accommodate 300 patients. The City Hospital is building an addition for children which will have 800 beds. Another one of the general hospitals is building a service building at \$85,000, and a new one is being built which will cost \$75,000. Duluth received a bequest of \$600,000 for a hospital and I believe intends to build it. It is a big one and will be in the iron and steel district, where the population has been increased, so that all sorts of buildings are required. Construction will proceed. In our section labor is plentiful.

With respect to the location of army and navy hospitals, I hope that when the War Department makes its plans for these hospitals it will bear in mind the Central West. In St. Paul and Minneapolis there is located an army post which would provide an ideal location for a hospital. We have a medical school at the University of Minnesota and also a post-graduate school. We are very anxious about the efficiency of these schools. So many medical men have left that we are getting alarmed. We believe that the location of an army hospital here would help in keeping some of the good medical men home. We are anxious to be of service to the nation by the training of nurses. Hospitals have increased their schools and have rented additional dormitories, and some could train more.

Dr. Goldwater called upon Dr. Peters to discuss the labor crisis which is now seriously affecting hospitals everywhere.

DR. PETERS: We have had troubles of our own, and it is a question of settling the problem from day to day. We are now advertising, but that is proving worthless as a way of securing people. We are substituting men for women and women for men. In our service a grave problem is the intern situation. We have lost a great many of our interns and today are short practically one-third. We are training one college

woman for laboratory work, and nurses for ward work and records. But a solution of the labor problem is out of the question. When a munition factory is opened across the street and offers three times the wages which we can afford to pay, we are helpless. Wages in the cotton factories have increased 60 to 70 percent in two years. In addition, there is no foreign labor coming into New England nowadays. We have factories and munition plants, and all the industries are extremely busy, and private institutions which must depend upon donations, do not know what to do. And on top of this we are requested to do work for the army and navy. The financial problem is a very difficult one.

DR. SEEM: All classes of employees can obtain wages with which we cannot begin to compete, and it is difficult to get any new labor.

DR. HOWELL: The orderly question is a serious one in New York. The army, however, recently sent us twelve enlisted men from Allentown to serve as orderlies. They remained six weeks and do very good work. I do not know if other hospitals are so situated that they can use them. These men had had no experience of this kind before. There were two sergeants in charge of the men, one with the night force and one with the day force. They were put in the hospital wards as orderlies under the direction of our own orderlies. We assigned two men on part time to the x-ray department and two to the laboratory.

MR. TEST: We have had some men from the Navy Department and they gave very good service. We had some of the orderlies from the base hospital for a few hours a day; if the men from Allentown measure up to the navy men, they must be satisfactory.

DR. GOLDWATER: Is the American Red Cross in a position to render assistance to civil hospitals in this country?

LIEUT.-COLONEL CONNOR: We have up to \$225,000,000 available now. The object of the Red Cross is to care for the unfortunate, whether by reason of military or civil disaster, and I can see no reason why that aid should not be extended to civil as well as to military hospitals. The funds of the Red Cross are being managed by men of broad vision and no one has ever seen aid refused to persons where there has been proved to be bona fide necessity. The majority of the money so far has been spent in France and Italy, but there is no reason to believe that if the civil community needs aid from the Red Cross as a war emergency that they will not get it. The money donated now is needed for the war and that was the basic argument in asking for subscriptions. If it is to be used for any civil purpose, it must be demonstrated that it is to help win the war. You have a strong argument, I am sure, if properly presented.

Dr. Goldwater asked the conference to vote on the following resolution:

Resolved, That the maintenance of the civil hospitals of the country in a state of efficiency is a military necessity, and that the attention of the American Red Cross be directed to the plight in which the hospitals find themselves as a result of the actual shortage of paid workers and in consequence of the inability of the hospitals to secure labor in the face of the competition of the government and of war industries.

The resolution was unanimously adopted.

MR. WRIGHT: In looking into the question of the reeducation of the wounded soldier, one of the primary necessities is the training of the teacher, not from the vocational end of it, but from the therapeutic end. In looking into the statistics, we found that out of 38,000 soldiers returned to Canada, 2,400 needed reeducation and vocational training and the balance needed therapeutics. There were facilities for training in the classroom, but a teacher, in order to handle these soldiers, is in need of bedside training, as the pupil nurse is in need of it; facilities for this did not exist. We got into touch with hospitals having industrial accident cases and asked if they would cooperate and there was a ready response. Private hospitals in this city have from one to five such cases of industrial disability, ununited fractures, stiffened joints, etc.—too few for any one hospital to organize a staff for training. A central hospital is needed. We are finding it difficult to raise funds except for soldiers. If the surgeon-general's office could be induced to say they would take such an institution over or place soldiers in it, there would be no difficulty.

The draft is revealing a large amount of venereal dis-

eases and tuberculosis. These men, if not accepted in the army, are turned back to society without any means for following them up or seeing that these conditions are corrected. It is going to be very unfortunate if we have all this knowledge coming to us and we do nothing about it. We have an organization in this state through whom we get hold of tuberculosis cases and they are being cared for, but there should be a government agency to see to this throughout the country.

In the location of these reconstruction hospitals, I wonder if due consideration has been given to the question of locating them in or adjacent to the large manufacturing centers. There are two reasons for doing this. In the first place, the men could be sent from the hospital direct to the manufacturing plant. It will be impossible to devise a hospital machine shop of sufficient variety for the things the men can do. But you will have a great variety of factories available if the hospitals are located near a large industrial center. There is another side to this. There are many expert medical men who are able to give a portion of their time, whose services would be exceedingly valuable, but under the present regulations of the surgeon-general's office they cannot be utilized. If the hospitals were located within reach of them and the services of these men could be utilized on part time, it would be a wonderful addition to the service of the government.

MR. WRIGHT: There will be many men discharged from the army for disability or for mental disease that existed prior to enlistment. Something should be done about these.

LIEUT.-COLONEL HORNSBY: There is no intention on the part of the surgeon-general's office that helpless soldiers shall be sent back uncared for. Arrangements have been made with state hospitals to care for mental cases until other arrangements can be made.

MR. WRIGHT: I know the government has made arrangements with state hospitals to care for insane soldiers. But I am speaking of instances where the condition existed previous to enlistment. That being the case, the army discharges the man and does not recognize any responsibility for him. At least the National Committee of Mental Hygiene have been so informed.

LIEUT.-COLONEL HORNSBY: The War Department has ruled that a man having been accepted in the army and having become a soldier, is entitled to all the rights and privileges of a soldier; the government does not expect to evade the care of any man subsequent to his enlistment merely because he acquired something before he entered; the army assumes all responsibility for him at enlistment and the government must assume responsibility for his care if he becomes incapacitated afterward.

* * * *

THE WAR AND INTERNS IN SPECIAL HOSPITALS

General Hospitals Should Give First Choice to Young Men Physically Qualified for Army Service

For two reasons the Department of the Surgeon-General of the Army has signified its desire to promote the education of interns in proper hospitals for as long a period as the exigencies of war will permit: primarily, that the future military surgeon may begin his medical career with as much professional experience as possible; secondarily, so that the organization of hospitals for civilian treatment and for instruction of physicians and nurses may not be unnecessarily disrupted.

How far do these considerations apply to certain special hospitals, such as hospitals for women, children, consumptives, eye and ear cases, and insane, and what should be the policy of the army with regard to interns in such institutions?

It seems clear that thorough education in all types of cases treated in the foregoing, except maternity and children's hospitals, will have definite value for military purposes and that the same policy with regard to interns in these should be followed as in general hospitals. Probably the children's hospitals may be placed in the same category as the others, as the medical and surgical experi-

ence gained therein is such 'as to afford a substantial foundation for military service, and this, taken into consideration with the desire to preserve the hospital organization, should warrant the placing of children's hospitals on the same basis as general hospitals so far as intern service is concerned.

With hospitals for women the situation is very different. Service therein is intensive in a branch of medical science which has no direct relation to military needs and, therefore, such hospitals can not receive the same consideration as other hospitals as places of preparation for military service.

On the other hand, it would seem that in such hospitals the organizations could be properly maintained by the aid of personnel not fitted for army service. Not every medical student is eligible for active military service of the kind to be anticipated and desired by the young medical man who has at last reached the place in his career where he can be of great value to the country.

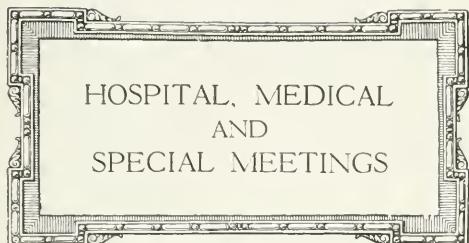
General hospitals should give first choice to those who are physically fit for the work in the army and navy, while young men who are not physically handicapped should likewise seek internships in hospitals where they can obtain the best possible training for military service. Those who, by reason of physical disqualifications, are not entitled to enter the country's service in its military branches should welcome the opportunity to aid in its general efficiency by engaging in other work essential to welfare.

Thus, by cooperation between hospitals and between hospitals and student, can we come nearer a solution of the tremendous problem of making the supply of medical men meet the requirements of war.

With the use of women physicians and medical students, and the proper allotment of student interns to places where they can be of the greatest use according to their qualifications, it would seem that an obvious difficulty may be at least minimized, and the authorities in medical schools can aid materially in advising their young men as to the proper course to pursue. Some men who have a special interest in obstetrics and gynecology may dislike to abandon the opportunity to specialize in such branches during the period of their internship, and surely the country cannot afford to be without the service of men so especially educated, but the needs of our fighting men are immediate and imperative, and our young men will no doubt be willing to sacrifice their personal ambitions for a time as many of the older men of the profession have already done.

The foregoing is the result of interviews with officers of the Surgeon General's Department by a representative of the American Hospital Association. It has been submitted to them and is believed to fairly represent the policy of the department with regard to interns in special hospitals.

Hospitals at home and abroad are threatened with a famine, seemingly trivial but in reality one that may cause considerable suffering—the palmleaf fan famine. A recent press item says: "One of the lines of export between Hongkong and this country temporarily destroyed by high freight rates and the high exchange value of silver is that of palmleaf fans. The common fans are simply the trimmed leaf and stem of the ordinary small palm which grows wild in most districts of south China. When cultivated or grown the palms are thickly sown, varying according to methods followed, from 5,000 to 10,000 plants to an acre, the fewer the plants the better the quality of leaf. About seven years is required for the palms to grow to the size necessary for a good fan."



A TIMELY AND SIGNIFICANT MEETING

Fourth Annual Convention of Ohio Hospital Association,
Columbus, Distinguished by Earnestness and
Patriotic Spirit

The Ohio Hospital Association met at the Hotel Deshler in Columbus, Ohio, May 28 and 29. The meeting was a significant one and decidedly characteristic of the times. The papers and discussions followed each other on time. Useless politics and useless arguments were absent. Some of the papers appear in this number of THE MODERN HOSPITAL; others will be published in early issues.

Mr. T. S. Bunn, superintendent of the Youngstown Hospital, presided in a way that seemed to get everybody down to necessary business, and the program and committee meetings, which were expected to take up the best part of three days, were finished in two, and finished well.

The keynote of the meeting was service. The papers in the main were about questions pertaining to serious problems which we must meet as war needs and meet as soon as possible.

The hospital men and women who attended the meeting were serious. They forgot themselves, their own point of view, and the self-interest of their particular hospital in the general need for team-work. The most frequent question asked was: "What does the government want us to do, and how can we do it?" They seemed to realize that public meetings have no right to use transportation facilities unless they met in this spirit. The Ohio meeting was a lesson in conservation and patriotism.

Mr. Bunn's opening address sounded the keynote of the meeting. The hospitals, he said, must readjust themselves to war needs, and must not make excuses for failure because interns and nurses, domestic labor or hospital and food supplies have to be readjusted or conserved. Mr. Bunn dwelt upon the necessity of conserving time and labor of physicians and nurses, the duty of the hospitals to train nurses as fast as possible, and to take the responsibility for civilian relief wherever possible. Mr. Bunn's closing sentence was indicative of the spirit of the Ohio meeting: "This is the time when personalities count only as they contribute to the cause to which every red-blooded man and woman should be dedicated in these days of the world's travail."

The report of the secretary, Dr. E. R. Crew of the Miami Valley Hospital, Dayton, was confined to a very brief reference to the printed report.

Miss Belle Sherwin, of the woman's committee of the State Council of Defense, told of the work of the women's organizations of the state, through the woman's committee, to increase the membership in the training schools and to cooperate with the hospitals and nursing organizations in increasing the present number and future supply of nurses for national service. Miss Sherwin's talk was

conservative and showed a splendid attitude in the lay women of Ohio in this work. The educational value of the work done was immeasurable; the actual results were gratifying.

Miss Florence Dakin, superintendent of the Middletown Hospital, gave an interesting paper on trained attendants,



DR. A. R. WARNER,
PRESIDENT OHIO HOSPITAL ASSOCIATION,
Superintendent Lakeside Hospital, Cleveland, Ohio.



DR. E. R. CREW,
SECRETARY-TREASURER OHIO HOSPITAL ASSOCIATION,
Superintendent Miami Valley Hospital, Dayton, Ohio.

an important subject in these days when we must conserve our interns and nurses.

Mr. John G. Bowman, who was to have read a paper on "The Present Status of Hospital Standardization," was unable to be present. The Rev. Father Moulinier, who



Members of the Ohio Hospital Association, assembled at Columbus for the fourth annual convention.

had planned to represent Mr. Bowman in his absence, was detained by illness in New York, and was unable to attend the meeting; Mr. F. E. Chapman, superintendent of Mount Sinai Hospital, Cleveland, who has been doing some special work for the American College of Surgeons, gave a short talk on the college requirements for classification.

The paper read by Mr. John C. Lapp, director of investigation of the Ohio State Health and Old Age Insurance Commission showed that the commission had put much intelligent study on the question of health insurance and that whatever conclusions they may reach, will be reached through a sane and humane attitude toward this, one of our most valuable "lessons from the enemy."

The early part of the Wednesday morning session was taken up by the round-table conference on war economics led by Mr. Bunn.

The first papers of the session took up conservation in the dietetic department of the hospitals. Miss Sarah Benedict, dietitian of the Miami Valley Hospital, Dayton, and Miss Bertha Beecher, of Christ Hospital, told of the way in which these hospitals are observing the regulations of the Food Administration and conserving wheat, meat, and sugar.

Miss Nell Stilt, of Lakeside Hospital, Cleveland, described how this hospital has saved materially in the use of gauze, and told the method of gathering, laundering, and sterilizing it for further use. Miss Stilt's paper appears in the War-Time Institution Economics Department, this issue.

Two excellent papers were read on hospital housekeeping problems, one by Miss Mary A. Jamison, superintendent of Grant Hospital, Columbus, and one by Miss C. L. Butterfield of Martin's Ferry, Ohio. These two papers gave the viewpoint and the problems of both the large and the small hospitals and the way in which the present shortage of labor and material is met in their institutions. Miss Jamison's paper is published in this issue.

Dr. A. R. Warner, superintendent of Lakeside Hospital, Cleveland, gave a very practical talk on laundry conservation, the use of proper machinery, and the system used at Lakeside which has saved and conserved their linen supply since it was put into use.

Mr. Frank E. Chapman's paper on the conservation of light and fuel was published in our June number.

Dr. T. R. Fletcher, acting chief medical examiner of

the Industrial Commission of Ohio, read an interesting paper on the work of his commission and in the discussion which followed answered questions from the floor asked by hospital administrators who have been endeavoring to come to a harmonious working basis with the commission.

Senator Howell Wright's paper was on the relations of hospitals to the state. This paper covered comprehensively the question of the authority of the state in the matter of inspection, licensing, and supervision of hospitals, and also something of the desired legislation on this matter.

A banquet was given in the hotel ballroom for the evening session. Mr. Richard P. Borden, secretary of the war service committee of the American Hospital Association, talked to the members of the association on the service of the civil hospital at the present time to do its share for a nation.

This last paper was given and heard by the audience in serious mood. Its lesson was this. Although the civil hospital can do very little directly at the present time for the returned soldier, there are two things of great value, things of absolute need for the care and morale of our men that they can do: first, to train nurses, and more nurses, and then more nurses; second, to provide civilian relief, to keep up the courage of the man in uniform by caring for those he has left behind. In this way the hospitals of this country, and those of us in them who for some reason or other must stay behind, can keep up the supply of trained women to care for the sick and wounded, and to help the recovery of those sick and wounded with the knowledge that mothers and fathers, wives and children are cared for while they fight for us.

The following officers of the Ohio Hospital Association were elected for the coming year: president, Dr. A. R. Warner, Lakeside Hospital, Cleveland, Ohio; secretary and treasurer, Dr. E. R. Crew, Miami Valley Hospital, Dayton, Ohio; first vice-president, Father M. F. Griffin, St. Elizabeth Hospital, Youngstown, Ohio; second vice-president, Miss Alice Thatcher, Christ Hospital, Cincinnati, Ohio; third vice-president, Miss Mary Jamison, Grant Hospital, Columbus, Ohio; executive committee, Mr. F. S. Bunn, Youngstown Hospital, Youngstown, Ohio; Mr. P. E. Behrens, Toledo Hospital, Toledo, Ohio; Miss Marie E. Lawson, City Hospital, Akron, Ohio; Mr. F. E. Chapman, Mount Sinai Hospital, Cleveland, Ohio.

VOCATIONAL THERAPY IN MENTAL HOSPITALS

The Annual Meeting and Exhibit of the American Medico-Psychological Association in Chicago—Artistic Quality of Products Made by Patients

The seventy-fourth annual meeting of the American Medico-Psychological Association was held at the Hotel La Salle in Chicago from June 4 to 7. The meeting was well attended and an interesting program of papers was presented. The discussion of the diagnosis and treatment of mental and nervous diseases and reeducational methods which have taken the place of custodial care made this meeting one of peculiar interest at this time, when everything which touches on the reconstruction of the disabled soldier and civilian war victim is of such vital importance.

Dr. H. G. Gahagan, who has made a special study of diversional occupation in his work at the state hospital in Elgin, Ill., was in charge of the exhibit. An unusually good display of handicraft was shown, representing 13 New York hospitals, 5 in Illinois, 2 in Canada, 1 in Maine, 5 in Massachusetts, 2 in the Carolinas, 1 in Utah, 1 in Tennessee, and 2 in California.



Fig. 1. Class in knitting at Binghamton State Hospital, Binghamton, N. Y. These patients are of a very low-grade type, who have become interested in work for the army and the Red Cross.

New York state exhibits were carefully classified and represented considerable work and study on the part of the chairman of the exhibit, Dr. H. M. Pollock, statistician of the New York State Hospital Commission. Wall charts and photographs were shown of patients suffering from various forms of psychosis who had made a definite improvement under diversional occupational treatment. Photographs illustrated the value of physical culture exercises and various drills. Accurately made baskets, cleverly made lace and embroidery, leather and metal work and plaster bas-reliefs, all the work of patients, were exhibited and one New York hospital showed a large painting, made by a manic-depressive from a small print of the well-known painting showing Philippe Pinel striking the fetters from the demented patients of the Salpêtrière.

The Anna Steele Hospital, Anna, Ill., showed some especially well-made embroideries on linen and beautifully crocheted filet lace. One strange and interesting specimen of this exhibit, the spontaneous work of a young negro woman in whom dementia precox developed following the race riots in East St. Louis, was a pair of white stockings, embroidered in ravelings from her black stockings and a red table-cloth. The designs were a highly conventionalized black cat on one stocking and a

seven-branched candlestick on the other, both surrounded by an elaborate medley of black and red dots.

Watertown, Ill., had a splendid industrial exhibit—men's tailored clothes, caps made from scraps of cloth, uniforms and dresses for various attendants and workers, brooms and cement work, all made in miniature, all



Fig. 2. Group of specimens of copper work, weaving, toys, basketry, and pottery made by patients in Danvers State Hospital, Danvers, Mass. The artistic quality and grade of workmanship in this exhibit are very high.

showing work of good economic value as well as of value in mental reeducation.

A Utah hospital showed accurate work in brush-making and basketry.

The Bangor, Me., hospital had some characteristic sailor and ship's carpenter handiwork, including a model of a rigged ship and log houses, and ship's chains and mallets hand-carved from wood.

The California exhibit was typical, too. The clay models and baskets savored of the early Spanish missions.



Fig. 3. Pottery class, Danvers State Hospital, and some of the products.

The exhibit of the Massachusetts hospitals was plainly indicative of the advance in arts and crafts made in that state. In the Danvers exhibit there were unusual examples of dull and glazed pottery, most artistic metal work, rugs that have a high commercial value because of their original designs, beautiful coloring, and accurate weave, and baskets that could take their place with pride on the shelves of an exclusive Fifth Avenue shop. One vase of American Indian design had been eight months in the making by a patient who had worked at it for four

hours a day. Taunton Hospital showed very good examples of pottery and metal work, and some artistic rugs.

The most unique feature of the whole exhibit was Mrs. Peggy Ann Sutton's quilt. This quilt is of the large old-fashioned bed size. It is backed with and quilted through white muslin and pieces of white ribbed underwear of various sizes and bordered with black cloth. The background is of solid embroidery of a buttonhole stitch in white embroidery cotton, and the whole thing is covered with figures of people, flowers, and animals, worked in ravelings from black and white and various colored cloth obtained wherever Mrs. Peggy Ann could get them. The figures represent relatives, friends, visitors, and employees of the hospital, and her friends in the farm and barnyard and garden. There are men, women, and children, young and old, thin and fat. Their clothing varies from high hats to farm hats and from shawls to present-day fashions in women's dresses and suits. The quilt is entirely the spontaneous, undirected work of this patient, a manic-depressive, 63 years old, of eleven years' residence in the Central Hospital for the Insane at Nashville, Tenn.

Treatment of mental disease in state hospitals has certainly made rapid strides in the last few years. Cards attached to handiwork in this exhibit show case after case history of patients who have shown decided improvement with diversional occupation therapy.

The following officers of the American Medico-Psychological Association were elected for the coming year: president, Dr. E. E. Southard, physician in charge of the Boston State Psychopathic Hospital; vice-president, Dr. Henry E. Eymann, superintendent of the Massillon State Hospital, Massillon, Ohio; secretary-treasurer, Dr. H. W. Mitchell, superintendent of the State Hospital for the Insane, Warren, Pa.

* * * *

Combined Meeting of the Canadian National Association of Trained Nurses and of the Canadian Association of Nursing Education

The annual meeting of the Canadian National Association of Trained Nurses was held in Toronto, June 4 to June 8, in conjunction with the meeting of the Canadian Association of Nursing. A joint meeting of the two organizations was held the first two days of the convention. The morning of June 6 was taken up by the reports of the president, the secretary, the treasurer, the standing and special committees, the affiliated organizations, and the *Canadian Nurse*.

The following papers were presented at the afternoon session: "Public Health Nursing in Manitoba," by Elizabeth Russel, superintendent of Provincial Public Health Nurses; "Public Health Nursing in Alberta," by Christine Campbell, superintendent of The Royal Alexandra Hospital, Edmonton; "Halifax Disaster and the Relief Work Done," by Miss Pickles, superintendent of nurses, Victoria General Hospital, Halifax; "The Infant Soldier," by Dr. W. W. Chipman, professor of gynecology and obstetrics of McGill University, Montreal; and "The Work of the V. A. D.," by Mrs. Henderson of Montreal.

At the business sessions held Friday and Saturday mornings, the subjects discussed were: plans for the *Canadian Nurse* for the ensuing year; the great shortage of graduate nurses throughout the Dominion and how to meet this national need; and the adoption of a new constitution and by-laws. Friday afternoon the delegates visited Hart House and the Davisville Orthopedic Military Hospital. In the evening a joint session was held with the Canadian

Association of Nursing Education, at which two addresses, followed by general discussion, were delivered, one, "Nurse Education," by Adelaide Nutting, Teacher's College, Columbia University, New York, and the other, "Introduction of Nurse Education in Canadian Universities," by Dr. Helen MacMurchy of Toronto. Elizabeth Robinson Scovil, of Gagetown, New Brunswick, read a paper on "The Duty of a Nurse to Her Nursing Journal."

* * * *

REHABILITATING THE TUBERCULOUS SOLDIER AND WORKER

Important Subjects Discussed at the Fourteenth Annual Meeting of the National Tuberculosis Association

The fourteenth annual meeting of the National Tuberculosis Association (until recently the National Association for the Relief and Prevention of Tuberculosis) was held on June 6 to 8 at the Copley Plaza Hotel, Boston. Prominent physicians and lay workers from almost every part of the United States were in attendance.

After the address of welcome to the city by the Hon. Andrew J. Peters, mayor of Boston, and the address of the president, Dr. Charles L. Minor, Dr. Charles J. Hatfield, the executive secretary of the association, read a report of the year's work. Through the office of the Surgeon General of the Army, he said, all men discharged from the army because of tuberculosis and those rejected by the examining boards are reported to the National Tuberculosis Association and through that body are brought in touch with facilities for adequate care and control in their own community, including antituberculosis agencies, boards of health, and the Red Cross, and every effort is made to see that each man is properly provided with sanatorium or home care and that his family does not suffer want. Thus far 11,000 soldiers have thus been reported and the system will be extended to cover every tuberculous soldier as long as the war lasts. Dr. Hatfield stated that the estimates previously made by the association, that at least 2 percent of the 10,000,000 men called in the first draft would be found on complete physical examination to have tuberculosis, have not been overstated.

The Red Cross Seal sale last year for tuberculosis work in this country yielded \$1,750,000. Plans are being made for a campaign to raise \$3,000,000 this year.

Nearly 700,000 children have been enrolled in the Modern Health Crusader movement, and under the direction of competent leaders are being taught how to care for their own bodies and how to protect the health of their own communities.

Thursday evening, under the chairmanship of Dr. George Thomas Palmer, of Springfield, Ill., was devoted to a discussion of tuberculosis as related to the war. Dr. James Alexander Miller of New York City read a paper on "How America is Helping France with Its Tuberculosis Problem." He reviewed at some length the work that has been done in France by the Commission on the Prevention of Tuberculosis, which is being supported by the Rockefeller Foundation, and of which Dr. Livingston Farrand, president of the University of Colorado, is the head. The commission is working in close cooperation with the French Government and the American Red Cross. Its aim is to show the French people how America is fighting to control the Great White Plague. Among the methods employed are special demonstrations by dispensaries, nurses, sanatoriums and hospitals in Paris and in one of the rural departments. Lectures, exhibits,

and other public meetings are being held in various parts of France. They are attended by thousands and the whole country is awakening to the fact that tuberculosis is a serious menace and that the American efforts to arouse community responsibility in the control of this disease may well be copied in France.

Col. George E. Bushnell, M.I., who is in charge of the tuberculosis division of the Surgeon General's Office, read a paper on "How the United States is Meeting the War Problem." Dr. Bushnell described the remarkable expansion of the personnel of the Surgeon General's Office made necessary by the war, the care which is being taken to weed out the tuberculous from the ranks and their subsequent care and treatment. He stated that the army now had at various points in the country 5,875 beds for use in the care and treatment of soldiers suffering from tuberculosis.

"How Canada is Meeting the Tuberculosis War Problem" was the subject of a paper by Capt. Jabez H. Elliott of Toronto, Canada. One of the interesting points he brought out was that the incidence of tuberculosis in the Canadian army had been less than that of the male civil population of military age. He urged the desirability of a scheme of graduated work among the patients at sanatoriums for both therapeutic and disciplinary reasons.

Friday morning and afternoon and Saturday morning were devoted to clinical, sociological, and pathological section meetings. The clinical section meetings were presided over by Dr. Walter R. Steiner, Hartford, Conn.; the sociological, by Mr. James Minnick, Chicago; and the Pathological, by Dr. M. C. Winternitz, New Haven, Conn. Papers read in the clinical section of special interest to hospital executives were a paper by Dr. J. A. Rutledge of Woodmen, Colo., on "Thirty-five Hundred Cases of Tuberculosis Which Have Been Treated at the Modern Woodmen Sanatorium for Tuberculosis," and one by Dr. J. Dworetzky on "The Institutional Care of Laryngo-Pulmonary Tuberculosis." In an interesting address entitled "Methuselah and Life in the Open," Dr. Vincent Y. Bowditch of Boston, deprecated the expensive systems of ventilation installed in many public buildings and extolled the simple devices used in open-air schools and sanatoriums for the treatment of tuberculosis as not only much cheaper but vastly more efficient.

The papers in the sociological section bristled with interest to workers in the hospital and social service fields. Dr. C. A. Prosser, secretary of the Federal Board for Vocational Education, Washington, spoke on the problems in the vocational reeducation of disabled men. He stated that figures compiled from the average of all belligerents show that for every 1,000,000 men mobilized, 10,000, or 1 percent of them each year, would be proper subjects for vocational retraining. On the basis of an army of 5,000,000 men, we would have 50,000 men each year who would need assistance and help in the restoration and increase of their earning capacity under the various classes of disability incurred. "Of the 10,000 men out of the million," Dr. Prosser continued, "fully 50 percent will require medical rather than surgical care—men who have developed tuberculosis, heart trouble, kidney trouble and functional disorders. The other half of the 10,000 must have some sort of surgical attention. Of the 5,000 surgical cases, there will, as the average shows us, be 10 percent in dismemberment cases where there has been a leg or an arm lost; and of these 500 men, 300 will have lost legs and 200 will have lost one or both arms. The figures show an astonishingly small percentage of blindness. Out of the 41,000 men returned to Canada, there were only 27 blind men.

"A study of these and other figures carries the conviction that this problem is by no means wholly that of the crippled or the maimed. It is the problem of the man who has a complication of troubles or injuries that, while surgical, do not amount to dismemberment; such, as for instance, as a man with the muscle of an arm shot away, causing him to lose the use of the arm.

"With such a diversity of injuries, being largely individual, so to speak, the work of reeducating these men becomes one which cannot be dealt with along broad, general lines, but each man will require individual treatment, individual study of his case, individual training and individual effort on his behalf in placement after he has been reequipped to take up the broken threads of civilian life."

Lieut.-Col. Harry E. Mock, M.R.C., Washington, D. C., could not be present at the meeting, and his paper on "Reconstruction and Rehabilitation Work for the Tuberculous in the Army" was read by Dr. Palmer of Springfield, Ill. Dr. Mock said that the soldier disabled by tuberculosis should be restored to complete physical usefulness just as well as one who has had his leg shot off. In reclaiming those in military service who have contracted tuberculosis and in securing their complete rehabilitation, a policy similar to that which has been worked out before the war in reclaiming men found to be unfit by medical examination in industry is being employed. Instead of allowing these patients to lie around sanatoriums doing nothing except reading and playing cards and becoming generally hospitalized, it is planned to start their rehabilitation during this period when their physical reconstruction is taking place. Patients in bed or in wheel-chairs will be taught certain useful trades or occupations. When discharged, if it is necessary, these men will be placed in special vocational schools where they will either be taught a new trade or made more proficient in their old one. The Surgeon General plans to keep close supervision over every tuberculous soldier until he is fully reclaimed.

Every soldier discharged from the army because of tuberculosis will be entitled to the following lines of treatment in an effort to reclaim him as a useful citizen: (a) the best medical treatment with certain adjuncts to secure the most rapid recovery; (b) certain occupations in connection with this treatment to prevent hospitalization and to refit for employment; (c) suitable employment after the disease is arrested or apparently cured, combined with proper medical, social, and economic supervision.

Practically every address at the Friday afternoon and Saturday morning sessions of the Sociological Section was devoted to some phase of employment as related to the tuberculous, whether on the farm, in an industrial colony, or in a factory. Dr. Martin F. Sloan, Towson, Md., delivered an address on "Farm Work for Tuberculous Patients at Eudowood Sanatorium." This farm colony was established in the spring of 1908. Its purpose was to take men and women in different stages of the disease whose lesions had become arrested and whose symptoms had been reduced to a minimum, perhaps a chronic cough, expectoration and shortness of breath, but whose sputum in most cases remained more or less positive and to give them supplementary treatment. Its idea was not primarily to convert a city man into a farmer or to help in back to the country movement. It has not been conducted with the utopian and impracticable idea of converting consumptives into agriculturists. The colony during the ten years of its existence has cared for almost two hundred cases in practically all stages of the disease but in

whom the lesions were quiescent. The work has consisted of raising poultry, swine, rabbits, sheep, and pigeons; trucking and canning; fruit and berry-raising; and, in some few cases, heavy field work. The physical results accruing to the patients have been in the main encouraging. Careful bookkeeping shows that as an economic measure this farm work system pays. The speaker suggested that, since the Federal Government will have a large number of tuberculous soldiers to care for, it would be well to look into the scheme with the thought of using its principles in caring for its tuberculous soldiers.

Dr. Bayard T. Crane, Rutland, Mass., read a paper on "The Training of the Sanatorium Patient in an Industrial Colony," in which he described the work now being developed in the hills surrounding Rutland, where a demonstration is being made of the economic value of the labor of convalescent tuberculosis patients. The work is both in agriculture and in the handicrafts.

Capt. J. R. Byers of the Canadian Army Medical Corps dealt with the problem of the returned tuberculous soldier in Canada. Here are two or three illuminating quotations from his address. "When I was called upon in 1916 to direct the treatment of some of Canada's returned tuberculous soldiers, I found that on account of the excitement, danger, and adventure of their life at the front, these men were not only indifferent to ordinary methods of treatment but openly rebellious against such methods. Thirty-three percent of those received at the sanatorium of Ste. Agathe des Monts, Quebec, during the first six months refused to remain and 15 percent had to be discharged for open insubordination. Concluding, therefore, that these ordinary methods simply increased the soldier-patients' irritation, I recommended to the military hospital authorities a new mode of treatment along vocational lines. This recommendation was adopted, and the results have been much better.

"As compared with the general apathy under the old system there has been great enthusiasm under the new regime. Insubordination has been reduced to less than 2 percent, and instead of refusal of treatment, there have been applications for extension of treatment to permit courses to be completed. Mental and moral conditions have been improved to a surprising degree. Each man's mind has been pleasantly occupied, his nervous system soothed, and his mental powers enhanced. While thus far no great percentage of men have been given a complete industrial training, a fair proportion have been fitted for civil service positions.

These results have convinced the Canadian Government of the benefit of the plan, which has now been extended to every hospital in Canada under the Department of Civil Reestablishment.

One of the most interesting and stimulating papers of the meeting was Mr. Edward Hochhauser's paper on "Three Years' Experience in the Employment of the Discharged Tuberculous Patients in Factory Work." Mr. Hochhauser contended that institutional care is incomplete and wasteful if patients are constantly relapsing. "In the final analysis the real test of effective care of the tuberculous is the return of the patient to economic usefulness and if possible a condition of self-support." Among the discharged patients placed at work by the Committee for the Care of the Jewish Tuberculous in their factory under medical and nursing supervision, the relapses have been reduced from 50 percent to 80 percent. The patients may be said to spend a period of industrial convalescence in the factory. The experiment, which has proved successful, was tried only after it was

found that suitable employment could not be found for the patients in ordinary factories. As only negative sputum patients are taken, the factory is primarily not a medical proposition but an economic undertaking. Mr. Hochhauser finds that the opportunity afforded to earn better wages than was otherwise possible, while also making progress back to health, proved a general stimulus and rehabilitated many individuals and families. The saving in relief in the case of those who formerly required charitable assistance has been far in excess of the cost of conducting the factory, and the families have had considerably more than they would have had if they had continued as relief cases. The saving in health and in relief would have justified the experiment even if at the end of three years our resources consisted solely of the equipment at the factory. As a matter of fact the factory has been entirely self-supporting for the last seventeen months and its resources as reported by certified accountants are equal to the amount advanced by the Committee for the Jewish Tuberculous. The experiment was described by Mr. Hochhauser in THE MODERN HOSPITAL (March, 1917, p. 207).

The latter half of Saturday morning was devoted to a discussion of the Framingham Health Demonstration, which is being conducted by the National Tuberculosis Association under the direction of Dr. Donald B. Armstrong. Dr. Armstrong reviewed the first year's results. Dr. P. C. Bartlett spoke on the consultation and medical examination work, while Miss Mary A. Abel covered the educational and organization activities. Many of the delegates spent the afternoon at Framingham, where the staff of the Community Health and Tuberculosis Demonstration held open house.

The following officers of the association were elected: president, Dr. D. R. Lyman, Wallingford, Conn.; honorary vice-president, Col. George E. Bushnell, U. S. A.; vice-presidents, Dr. Lawrason Brown, Saranac Lake; Dr. Lee K. Frankel, New York; secretary, Dr. Henry Barton Jacobs, Baltimore; treasurer, William H. Baldwin, Washington, D. C.; executive committee, W. Frank Persons, Washington, D. C.; Dr. O. O. McMichael, Chicago; Dr. Charles L. Minor, Asheville, N. C.; Dr. H. E. Dearholt, Milwaukee, Wis.; Dr. Fred L. Hoffman, Newark, N. J.; Dr. E. R. Baldwin, Saranac Lake, N. Y.

Resolutions were passed pledging the support of the National Tuberculosis Association to the directors of the Army Medical Museum in their efforts to secure appropriations from Congress for a new building and new equipment and for the expansion of the museum to make it eventually a center for medical teaching and research; requesting that Surgeon-General Gorgas be continued in active service in the office he now fills so admirably, so that neither his work nor his plans may be interrupted; and affirming the necessity of a prompt increase in the number of beds in the tuberculosis hospitals and sanatoriums throughout the United States and urging that the capital issues committee of the Federal Reserve Board of the United States Government allow permanent buildings to be constructed in all cases in which the difference is not too great in order that it may not be necessary to repeat the process a few years later or to waste the money which it is so difficult to obtain for any kind of construction.

* * * *

Meeting of the Michigan State Nurses' Association

The Michigan State Nurses' Association, which held its annual meeting at Bay City, May 21 to 23, elected the following officers for the ensuing year: president, Eliza-

beth Parker, East Lansing; first vice-president, Fantine Pemberton, University of Michigan Hospital, Ann Arbor; second vice-president, Lucy E. Ramstead, Newberry; recording secretary, Annie M. Coleman, Oakland Building, Lansing; corresponding secretary, Anna M. Schill, Hurley Hospital, Flint; treasurer, Christine M. Hendrie, Blodgett Memorial Hospital, Grand Rapids; councillors, Lystra E. Gretter, Detroit, and Ida M. Barrett, Blodgett Memorial Hospital, Grand Rapids; chairman, standing ways and means committee, Effie M. Moore, Detroit; chairman, credentials committee, Effie Tyrel, Battle Creek; chairman, nominating committee, M. S. Foy, Battle Creek Sanitarium, Battle Creek; chairman, printing committee, Harriet Leck, Grace Hospital, Detroit; chairman of the special committees, Lystra E. Gretter, Red Cross committee, Detroit; Ada P. Coleman, public health committee, Grand Rapids; and Mary A. Welsh, legislative committee, Blodgett Memorial Hospital, Grand Rapids.

* * * *

First Annual Meeting of the Minnesota Hospital Association

The first annual meeting of the Minnesota Hospital Association, organized in April last year, was held in Minneapolis, June 27 and 28, at the new Curtis Court Hotel.

A comprehensive program dealing with general and wartime problems was presented, one whole session being devoted to the discussion of the nursing problem of the smaller hospitals. A round-table conference on conservation and every-day economies and details of hospital management was a valuable feature of the program. An automobile drive around the lakes within the city and luncheon at one of the near-by country clubs furnished pleasant diversion.

The officers of the association are: Dr. G. W. Olson, superintendent Swedish Hospital, Minneapolis, president; Lieut. G. H. Murray, late superintendent More Hospital, Eveleth, now at Camp Dodge, Iowa, first vice-president; Rev. J. A. Krantz, superintendent Bethesda Hospital, St. Paul, second vice-president; Sister Mary Joseph, superintendent St. Mary's Hospital, Rochester, third vice-president; Mrs. G. G. Eitel, superintendent Eitel Hospital, Minneapolis, secretary-treasurer. These, with Miss Harriett Hartry, St. Barnabas Hospital, Minneapolis; Rev. Henry Hartig, St. Andrew's Hospital, Minneapolis, and Dr. S. G. Cobb, Cobb Hospital, St. Paul, constitute the executive committee.

An Illinois Course for Community Nurses

Plans have been practically completed for the establishment in Springfield of a two-month emergency post-graduate course for community nurses to be conducted by the State Department of Public Health, the State Department of Public Welfare and the Illinois Tuberculosis Association, with the cooperation of the Chicago School of Civics and Philanthropy, the Elizabeth McCormick Memorial Fund, the Chicago Tuberculosis Institute and other state local health and welfare organizations. The course will occupy but two months and no fees or charges of any kind will be made. Only graduate nurses registered in Illinois or in the states in which they reside are eligible to the course and in filling the classes preference will be given to those who agree to engage immediately in public service nursing in Illinois.

Those who are responsible for the development of this course recognize that the time allotted is not sufficient

for thorough training in community work, but this special course is arranged particularly as a matter of emergency to meet the acute need for community nurses brought about by the demands of the American Red Cross for military service and by the tremendous development of the many social activities in Illinois within the past year.

According to the tentative plans now under consideration, three weeks of the course will be devoted to didactic and practical instruction in Springfield, after which the nurses will be sent in small groups to serve in the visiting nurse services of the several Illinois communities in which medical social work is being carried on with a high degree of efficiency. One week of the course will be spent in tuberculosis sanatoriums or hospitals in which intensive public health instruction will be given. The final week will be spent in Springfield and will be devoted to examinations, round table discussions and the rounding up of the course.

The faculty for this course will be drawn from the staffs of the State Department of Public Health, the State Department of Public Welfare, the Illinois Tuberculosis Association, and the Elizabeth McCormick Memorial Fund, and it is expected that part of the instruction dealing especially with state charities will be carried out in the several state institutions. The fields included in this brief course of instruction are communicable diseases, rural sanitation, general visiting nursing, tuberculosis nursing, dispensary methods, child welfare, school nursing, juvenile and adult delinquency, jails and almshouses, mental hygiene, health service, elementary laboratory methods, all of these subjects being given consideration especially from the small community standpoint.

Aside from the many vacancies in community nursing service brought about by the demands of the American Red Cross, a large number of counties and municipalities have recently appropriated funds for public health and social service nurses, while funds for fifty additional community nurses were created this year through the sale of Red Cross Christmas Seals.—Illinois Health News.

Great Work Accomplished by the Canadian Red Cross in 1917

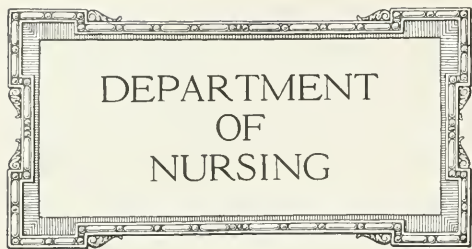
The work of the Canadian Red Cross since the outbreak of the war has been tremendous. This society is subdivided into 772 local chapters; 6 hospitals have been organized in England itself; 28,500 crates of hospital material, etc., have been distributed among various hospitals in France and Africa through the medium of the French Red Cross societies.

The Canadian Society also supports recreation huts for convalescents. The 59 ambulances belonging to the association transported more than 32,500 wounded during the summer months of 1917.

In 1916 the Canadian Red Cross contributed \$365,000 for wounded soldiers of the United States forces, according to information recently communicated to the national headquarters of the American Red Cross by the chairman of the executive committee of the Canadian Red Cross.—Red Cross Bulletin.

Canadian hospitals in France are helping to care for Red Cross work in France alone.

There are three kinds of people in the world: the Wills—the Won'ts—and the Can'ts. The first accomplish everything; the second oppose everything; the third fail in everything.—Friend's Calendar.



Conducted by MISS ANNIE W. GOODRICH,
Teachers' College, Columbia University, New York City.

Please address items of news and inquiries regarding Department of Nursing to the editor of this department, Teachers' College, Columbia University, New York City.

THE ARMY SCHOOL OF NURSING

Plan for Furnishing Nursing Care to the Sick and Wounded in Military Hospitals

The authorization, by the Secretary of War upon the recommendation of the Surgeon General of the Army, of the establishment of the Army School of Nursing has put into operation a plan whereby the sick and wounded men in our military hospitals may receive care through the method that has been found most effective in the civil hospitals. The school will also afford the opportunity so eagerly sought by our young women for patriotic service and, through the high standard for admission and the thorough professional training it is prepared to provide, gives promise of an army of highly qualified nurses to carry on the reconstruction work that will be needed after the war in this and other countries. The course as planned leads to a diploma in nursing should the military hospitals continue in operation for the full period of the course. Should the cessation of hostilities occur before the completion of this period, credit for all branches of nursing completed will be given in a certificate by the Army School of Nursing, which certificate will entitle the holder to recognition by such civil hospital training school as may subsequently accept her as a student. The school is located in the Surgeon-General's office, Washington, D. C.; the training will be given in the various military hospitals and through such affiliations as may be required to complete the course.

The military hospitals will provide experience in surgical nursing, including orthopedic, eye, ear, nose, and throat; medical, including communicable, nervous, and mental diseases. Experience in the diseases of children, gynecology, obstetrics, and public health nursing will be provided through affiliations in the second or third year of the course.

Lectures, recitations, and laboratory work will be given in the required subjects, each hospital assigned as a training camp having its staff lecturers, instructors, and supervisors, and teaching equipment.

The course extends over a period of three years. Credit of nine months, or approximately an academic year, will be given to graduates of accredited colleges. Credit of three or four months will also be given to students who have had two or more years of college work that has included prescribed courses in the sciences.

To be eligible to the Army School of Nursing, candidates must be between 21 and 35 years of age, in good physical condition, and of good moral character. They

must be graduates of recognized high schools or present evidence of an educational equivalent.

No tuition fee is required. The students will be provided with board, lodging, and laundry throughout the period of the course, and with the required text books. They will be required to provide themselves with indoor uniforms for the preliminary course, and upon its successful completion, with an outdoor uniform, and such additional indoor uniforms as are required during their residence in the school. A monthly allowance of \$15 to meet these and other school expenses will be provided, except for the period of affiliation.

It is hoped to establish the first units on or about July 1. The board of the Albany Hospital, Albany, is releasing Miss Sallie Johnson to establish a unit in the vicinity of New York. Similar assistance is being considered by the board of directors of other important hospitals.

The advisory council appointed to advise concerning the affiliations with the civil hospitals and the general policy of the Army School of Nursing is composed of the following members: Colonel W. H. Smith, chairman; Colonel C. L. Furbush; Colonel W. T. Longcope; Miss M. Adelaide Nutting; Miss Lillian D. Wald; Miss Anna C. Maxwell; the superintendent of the Army Nurse Corps; the superintendent of the Navy Nurse Corps; the director of the Department of Nursing, American Red Cross; the president of the American Nurses' Association; the president of the National League of Nursing Education; the president of the National Organization of Public Health Nursing; the dean of the Army School of Nursing.

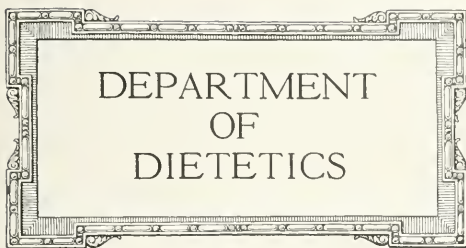
In many of the military hospitals are to be found men and women prominent in the medical and nursing world through whom the school is assured of a strong faculty.

The school is fortunate in obtaining the services in the office of the school of such prominent nurses as Miss Helen Scott Hay, who has been released by the American Red Cross office in Washington, Miss Ellen Stewart, formerly superintendent of the Clarksons Memorial Hospital, Omaha, Neb., Miss Anna C. Jamme, who has been given a leave of absence by the State Board of Health of California; while Miss M. M. Riddle of the Newton Hospital, Mass., has been released by her board of directors to establish in the immediate future the training unit at Camp Devens.

The Women's Committee of the Council of National Defense, the Red Cross, and the Nursing Committee of the General Medical Board of the Council are preparing an extensive program for the recruiting of students for both civil and military hospitals. Great and sympathetic interest in the Army School of Nursing has been already demonstrated by the various branches of the Junior League, an organization that represents many young women who would like to render this service at this time.

Hostels for Disabled Men

A new Eccentric Club hostel was opened at 5, St. Agnes-place, Kennington Park, on May 2nd, by the lord mayor of London. The house has been provided by Mr. Walter De Frece for the accommodation of disabled and discharged men from Roehampton Hospital while they are learning trades, and will contain 25 beds. This is the thirteenth hostel which the Eccentric Club has fitted up. . . . There is a waiting list at Roehampton Hospital of many thousands. Already the club has provided for nearly five hundred of these men, and five more hostels will shortly be opened.—Lancet.



Conducted by MISS LULU GRAVES.

Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, in care of THE MODERN HOSPITAL, Conway Building, Chicago.

In the May issue of THE MODERN HOSPITAL there was published in this department a paper on "The Economical Preparation and Serving of Food," by the editor of this department, which was read before the Ohio State Hospital Association a year ago. Unfortunately, this paper was printed without proper revision. Mention was made therein of the need of saving potatoes, and some foods which might be used to help in conserving potatoes. This furnishes one more proof of the danger of making definite statements with reference to our food supply. This situation is changing so rapidly that the thing we advocate doing this month may not be at all the thing to do next month; the statement made in regard to the use of potatoes a year ago was decidedly an error at this time.

The following are "pointed paragraphs" taken from the bulletins on food conservation sent on by the department at Washington:

WHY RYE FLOUR WAS REMOVED FROM SUBSTITUTE LIST

"Numerous inquiries have come to the Food Administration asking why rye flour was removed from the list of substitutes for wheat flour. On May 1 it was estimated that there remained but 16,000,000 bushels of rye in the United States. Against this amount our normal consumption of rye from May 1 to August 1 amounts to 31,000,000 bushels. If rye flour had been continued on the substitute list our available supply would not have lasted one month. In order that there might be even a limited supply for the normal uses of rye flour, this cereal was taken off the substitute list."

POTATOES FOR WHEAT

"America has fallen behind in its shipments of food to Europe. We must make up our obligations now by sending more cereals, especially wheat. Eating potatoes is one way to increase the supply of wheat.

"We have the potatoes—millions of bushels are available now; they won't be as good three months from now. To conserve both wheat and potatoes

"Eat Potatoes
now
and

get such an enthusiasm for potatoes that next year's production will beat this year's.

"Germany gets 200 bushels of potatoes to the acre, the United States less than 100 bushels. Germany raises five times as many potatoes as the United States in less than one-tenth our area. We can and will do as well.

"But that's for the future. For now, Eat potatoes; save wheat—and redeem our obligation to the allies."

WHEAT SAVING IN HOSPITAL

"The largest hospital in the state of Maine has been saving from four to six barrels of wheat flour a month since the inauguration of the savings campaign. This saving has been effected by the increased use of cereals

with sugar and milk or cream. The hospital practically averages four and two-thirds wheatless days each week. Everything possible in cooked foods requiring sugar has been cut out and every possible means is used to save food. All this is done without reduction in sustaining value of food served."

* * * *

FOOD CONSERVATION IN MILITARY HOSPITALS

Reduction of Waste at Camp Sevier Base Hospital Through the Work of a Food Conservation Board—Cooperation of Cooks and Men an Important Factor

"An economical use of food has always been fundamental to really good housekeeping," says the *Military Surgeon*, "and the appeal now making to 'save food and win the war' has no application to such, for 'saving food,' in the proper sense of the term, is the essence of good housekeeping. But a good housekeeper is a *rara avis*, and such birds are usually of the feminine gender, while among men housekeeping, like olives, is an acquired taste and rarely reaches above mediocrity." Thus runs the editorial introduction to the following views of Major John S. Dye, M. R. C., on duty at Base Hospital, Camp Sevier:

To send two hundred and twenty million bushels of wheat to our allies, when we have a surplus of only eighty-nine millions, seems impossible until we realize that to have the required surplus we should get it down to a concrete basis and know the part that each individual must play; then it looks easy, for if each person saves weekly 1 pound of flour, 7 ounces of meat, 7 ounces of sugar, and 2 ounces of fat, it is done. After our personal experience in food conservation at this hospital the statement that "Enough food is wasted in America to feed France" appears to us a fair, but awful indictment.

Early in the organization of this hospital it was realized that a great deal of good could be accomplished by proper conservation of food and prevention of waste. There have been apparently insurmountable obstacles presented in this work, such as inexperienced cooks, unaccustomed to handling army rations, inexperienced help in all departments; and with the exception of the commanding officer and one other officer, there was not a single man connected with the base hospital here with any considerable army training. On or about October 25, 1917, Major Scott, commanding the base hospital, detailed verbally Major E. H. Goodman, Captain C. W. Woodall, and myself to look into the matter, and a few days later issued the following memorandum, at our suggestion:

MEMORANDUM

1. After each meal, all foods that are left from the various messes of this hospital will be separated into different kinds, such as meats, breads, vegetables, etc., and will be inspected by an officer before it is incinerated.

2. Lieutenant Woodall will make this inspection at the general mess, and Major Dye at the officers' mess, nurses' mess, and the hospital corps' mess.

3. Bread will be sent into the wards in loaves and cut there, and the slices, after being cut, will be cut in half and served. Foods sent back from the wards will be inspected before incinerating.

4. Note will be taken of the amount of waste from each ward and a report of the same made to the mess officer. Medical officers and nurses in charge of wards will use every effort to prevent the waste of all foods, particularly bread, butter, meats, and sugar.

5. Food sent to the contagious wards will be sent in containers; great discretion will be used in the amount served to all patients, and the food remaining in the containers will be sent back to the mess and utilized. The bread sent into the contagious wards will be left there and used in making milk toasts, etc.

6. Food remaining in all other wards will be sent back to the mess and utilized.

7. The mess officer and the officers' mess, the mess officer of the hospital, of the detachment, and the nurse in charge of the nurses' mess will send a menu of food served, to Major Dye's office daily.

8. The following food conservation board has been appointed at this hospital: Major John S. Dye, Major Edward H. Goodman, and Lieutenant Charles W. Woodall. This board will act as a permanent advisory board in all matters pertaining to the supply, conservation, preparation, and serving of foods in the hospital, and their recommendation and orders regarding the same will be obeyed and respected.

(Signed) T. E. SCOTT,
Major, M. C., Commanding.

This board was to exercise a wide range of power in all matters connected with the messing facilities of the hospital. It was made plain that the object of this board was not to reduce the food of the patients to a minimum; that all patients must have a sufficient amount of food, well prepared and served in an appetizing manner; so that there could be no excuse for waste on the part of consumers; that every man was to have all the food he desired; *that no one was to waste anything.*

The board then proceeded to make a complete and careful survey of the situation. It found that a great deal of food was not well prepared and not appetizing, due to the inexperience of the cooks, that the cooks themselves were making no effort to save food, and the patients were also wasteful in the use of food. Captain Woodall, the mess officer, found on investigation that the medical department men were getting 5,500 to 6,000 calories per day; this was considered too much. The caloric value of foods fed to patients was also worked out for each meal for a period of seven days, showing that the regular diet patients received on an average of 2,500 to 3,000 calories, light diets 2,200, and liquid diets 1,000 calories per day. This was considered a sufficient amount for men not performing manual labor. Experiment has shown that an individual in bed eight hours, and resting in a chair sixteen hours, uses 2,168 calories, while men on light duty, resting most of the time, will use 2,488 calories. A balanced menu, based on the above figures, is worked out each day, and this is multiplied by the number of men to be fed. We have found that the number of calories arrived at by this process is more than sufficient to satisfy the hunger and meet all physiological needs of the men. Men resting in the hospital do not require a diet of 3,500 calories, and such an amount is directly injurious in many cases in that it throws extra work on the metabolism of an individual whose physiological functions are below normal.

The first problem of the board was to secure earnest cooperation from the cooks and men handling the foods. With this object in view lectures were given to the medical department men, showing the necessity of saving and the methods by which it could be done. Cooks were given special talks and instruction in saving food, during its preparation. This propaganda of instruction was extended to the nurses so as to get their cooperation in the ward diet-kitchens. In each one of these talks, it was urged that everyone write to the families and try to start a food conservation propaganda in the homes. For the purpose of interesting patients in the hospital and securing their entire cooperation, various signs were printed and hung in each ward. These are circulated daily so that a new sign is in each ward every day. . . .

This bulletin was issued by the board:

Conservation of Meat.—There shall be one meatless meal each day and two meatless days each week, for all the messes in this hospital, including the officers' mess, sub-

stituting for meat, sea-food and articles of vegetable diet rich in protein.

Conservation of Wheat.—There shall be one wheatless day, or three wheatless meals served during each week, corn, rice, and other cereals being substituted for wheat.

Conservation of Sugar.—All sugar and desserts requiring sugar will be eliminated from the noon-day meal, except on Sunday.

Conservation of Fats.—No butter will be served at the noon meal except on Sunday, and the frying of food in fats will be avoided as much as possible.

Conservation of Waste.—At the end of each meal one of the board will inspect the waste from each mess, and the food returned from each ward, before it is incinerated or thrown into the garbage-cans. No meats, breads, cereals, or potatoes, even if they have been on a man's plate, will be wasted, but it will be recooked and served again, except the food returned from the contagious and venereal wards. Bread will be sent to the wards in loaves, and the ward surgeon or nurse in charge will see that the slices are cut thin and then cut in half. The patient may have as many half slices as he requires. In the contagious and venereal wards, the bread will not be returned to the mess, but kept in the ward for making toasts.

When waste is discovered in foods returned from a ward, it is reported to the mess officer, who in turn calls on the ward surgeon for an explanation. Nurses and ward surgeons are held responsible that no waste occurs. Food is taken into the wards in quantities, and individual service made from the ward diet-kitchen. Any excessive waste from a ward is not only ample proof that negligence has occurred, but is also proof that a sufficiency of food is served to the ward; so that a nurse stating that her patients have not had enough to eat must first show that she has not thrown into the garbage-can food intended for such patients. The object of the board in controlling this waste has been to place the responsibility for the waste directly on the person who is responsible, and in this way immediate and definite results are obtained. Ward surgeons and nurses are instructed by the mess officer that they may have for their patients all the food desired; that if one serving is not sufficient, as many more as are necessary may be made, so that there has been no restriction whatever in the amount of food furnished the wards. It is only that they must show that such food has been properly used and none wasted. This statement is in apparent contradiction to the statement that a certain number of calories of food are furnished to certain classes of patients, but rations prepared by our caloric estimates have proved more than ample, so that the surplus enters into the estimate of the amount to be cooked for the next meal. Special diet cases, and seriously sick cases, of course are fed all articles required by the ward-surgeon, no restrictions whatever being placed on these.

All kinds of foods, such as meats, bread, and vegetables, are returned from the wards in separate dishes. In the kitchens the cooks keep their various kinds of waste in separate containers. Dirt is matter out of place; garbage is food out of place.

Because of the work of our board, the reduction in waste has been most remarkable. From an inordinate waste of large amounts of perfectly good food, and particularly of those foods that we must save—wheat, meats, fats, and sugars—the hospital has reached a point where there is not more than one ordinary garbage can full of waste daily, most of this being vegetable material that cannot be re-served. Apple and orange peeling, celery tops, and other coarse materials are not included in this estimate.

Happy is the man who does all the good he talks of.—Italian proverb.

HOSPITALISM—ITS CAUSES AND TREATMENT*

Definition—Personal Causes: Poverty, Malingering, Laziness, Lack of Will Power, Imperfect Diagnosis—General Causes: Social Conditions, Lack of Facilities for Diagnosis, Misconception as to Purpose of Hospital—Treatment—Hospitalism in Relation to Employees.

By PLINY O. CLARK, Superintendent of the Ohio Valley General Hospital, Wheeling, W. Va.

In the somewhat brief and incomplete discussion which is to follow we are to consider "hospitalism" in its bearing not only upon the patients in our hospitals, but upon our employees as well.

For some years there has been in common usage about the hospital corridors a term by which an attempt has been made to define a certain class of patients. You have heard and so have I, "What's wrong with the patient in A 6?" "Oh, nothing but 'hospitalitis'." This class is not at death's door. It is not moribund ordinarily, but it comprises those who under right surroundings and circumstances would be physically and mentally well. It is the average patient; that active class not acutely ill, but who ordinarily are in a chronic condition of whom we would speak.

DEFINITION

What, then, is "hospitalism" or "hospitalitis"? One says, "It is the disease of enjoying a hospital"; another, "It is the term applied to that one who simply has the hospital habit." Certain it is that it does not refer to the hospitalization of the people; or to the increasing popularity of the hospital in these times when people go to the hospital to get well, not to die. It refers to a somewhat indefinite, sociological problem. It does not refer to the dictionary definition, "Hospitalism is that morbid state due to impure air in a hospital," nor could we state with truth that it is caused by any mechanical part of such an institution, but it would seem to be comprehended for the moment in this definition: "Hospitalism is that state of apparent satisfaction with his surroundings or lack of personal initiative which permits a patient, often in a chronic condition, to enjoy the care of a hospital to an abnormal degree."

Again, it refers to those who, not passively, but actively because of social conditions or accidents, and themselves unable to see the reason for their own failure, are forced to turn to that institution in the community which replies to the statement, "I'm sick" by, "What's wrong? Let's see." The term cannot rightly be applied to those whose case has been improperly diagnosed.

We should further limit the discussion of "hospitalism" and confine it to that class commonly known as "the poor," for, as one of my friends has so happily remarked, "Hospitalitis in the wealthy patient is usually incurable, for the hospital usually dare not, and the patient usually will not, do what he ought." Of the wealthy, then, we will not speak at all, but of the larger problem which interests us just at present, that of the care of the poor and great middle class.

PERSONAL CAUSES

The causes of "hospitalism" may be either personal, referring to the patient alone, or may be general and make society responsible for their origin. Among the personal causes we would place as most important *poverty*. The vicious cycle, "poverty, sickness, poverty" or "sickness, poverty, sickness," is without doubt the cause of a great

deal, if not the major portion of our "hospitalitis" cases. We might divide this poverty-stricken class into two subdivisions; first, that in which life is a defeat and the individual is unable to maintain itself in the great struggle for existence, and, second, that class in which life is a struggle, but not a continual, an everlasting defeat. Any remedial measures applied to the former class of patients are practically worthless, unless they can be lifted out of their class entirely into the second, and even there they will need assistance and temporary relief at many turns of the road. The question of the bearing of poverty upon the "hospitalitis" case is a large one and can best be solved by the sociologist. Of the treatment a little later; sufficient now to speak of poverty as a cause of "hospitalism."

Another cause of "hospitalism" is the development on the part of the patient of a real affection for the hospital, for the nurses, the physicians, all in attendance. Compared with the home surroundings, the hospital is a veritable heaven, the nurses ministering angels, the physicians wizards of superhuman knowledge. Is it any wonder that after discharge such patients easily trump up an excuse to return? Why, I have even known of such among wealthy patients who, after a pleasant hospital experience, even though a most serious surgical operation has been undergone, would greet you somewhat after this fashion:

"I want to tell you what a delightful time I have had while I have been here these three weeks. It has been so restful, so free from care. Everybody has done everything they possibly could to make my stay pleasant and I have told my husband that when he goes off for his vacation up in the mountains, I'm going to return here for mine, just for a good rest and to enjoy it without the suffering."

A third class is the malingering, pure and simple, a class represented as such in medical circles.

To illustrate, let us use the words of the executive of one of our best hospitals:

"A single man of 30, a member of a sick benefit lodge, which was paying his hospital expenses, complained of stomach trouble. After the patient had been a week in the hospital, the doctor, finding no serious trouble, told him to go home. The man did not wish to go, and the next day complained of a serious pain in his knee. An examination showed nothing the matter, and it was decided the man was looking for a place to stay and take it easy as long as the society would foot the bill. He was put on a diet of soup, and a fly blister put on his knee. He left the hospital entirely cured the next day."

A fourth class might be associated with the malingeringers, and yet they are truthful enough, are lazy, or perhaps, they lack will power. They are those human parasites which occur in every large community referred to facetiously by the youngsters in a certain town:

"Buffalo Bill lives on a hill.
He never works and he never will."

The treatment for this class would be to secure sentence under some of our war legislation, which makes imperative thirty-six hours' labor in a week or imprisonment. One of our good friends suggests, "Simply give that fellow a war job."

In a young class is the neurotic, and he needs real consideration. Very often the physician and the nurse pass by him, merely saying, "Oh, he's simply got a case of nerves. Nothing much the matter with him." Says the superintendent of a large Eastern hospital:

"Personally, I have always felt, and my feeling increases with the years, that the doctors and hospital people are entirely too ready to consider a person neurotic or 'hipped.' I am absolutely certain in my own mind that many of the patients who are accused of being neurotic, or who have 'hospitalism' as I understand it, really have some

*Read before the American Hospital Association at its nineteenth annual session, Cleveland, O.

condition which the doctors have not discovered. We all know that there are many obscure cases, and when the doctor cannot put his finger definitely upon the spot it is very easy to blame it on the nerves."

The treatment of this class, provided, of course, the diagnosis has been established, and the case is one of "nerves," should be given to the neurologist, who with his suggestive therapeutics, mental therapeutics, hydrotherapeutics, or his electrotherapeutics may restore the normal condition.

Right here is where we may learn much from our present enemy, the German, who for many years has made so much of his bath house. Perhaps, with the war's new demands for curative agents, we will turn to similar means for assistance in our new treatment work and make some decided advancement along therapeutic lines.

Fifth, there are those who are hospitalized or have "hospitalitis" because of some great misfortune or accident; for instance, industrial workers not under compensation laws, or our soldiers, maimed and disqualified for military duty and cut off from their ordinary occupations when discharged; no longer able to make a livelihood through the accustomed channels, they have no heart to learn a new trade.

Special treatment is needed by this class, and this is particularly true of our soldiers who may be returned incapacitated for future duty in the army. They must first be brought back to health and then receive such specialized treatment as will place them at least in a self-supporting position. Canada has much to teach us in this line; much of good, many mistakes. It is all very interesting, and should receive our most careful attention now.

Perhaps we will have no case so extreme as the following, yet it will serve as an illustration: There was a group of Jamaicans who had served the mother country in the war, been wounded and sent to Canada for convalescent treatment.

"Nine had had both legs amputated below the knee, eight lost one foot or most of one foot. In the West Indies they had been cultivators, earning from ten to fourteen shillings per week. Their case was taken up by the Canadian Military Hospitals Commission with the government of Jamaica, which reported that if the crippled men could get training as shoemakers or garment-makers, they could earn a livelihood on the island. In less than five months eight of the men were trained to the point where they could do ordinary shoe repairing as well as the journeyman; two showed such aptitude for cobbling that they could make custom-made shoes. Three showed a 60 percent efficiency as garment-makers. One, in tinsmithing, could make an ordinary utensil if given the pattern, although he was of such a primitive type that he could not distinguish differences smaller than a quarter of an inch. One was trained to be a chauffeur (he had had some experience before); and one completed two-thirds of a course in stenography and typewriting. . . .

"Jamaica paid the cost of maintaining, equipping, and training the men. Instead of the unskilled farm hands who had left the island, instead of helpless war cripples, prospective dependents for unnumbered days, seventeen producers, with enough artisanship to earn for themselves more than they had ever earned before, they sailed south from Halifax to take up life hopefully in spite of their desperate maiming."

There must be the planning for systematic vocational work, if instead of discouraged, dependent, pensioned, or "hospitalized" wrecks in the worst sense of the term, we are to have those who are self-respecting, self-supporting citizens. As hospital people realizing the need, it will be our duty not only to provide adequate hospital facilities to bring back health to our returning soldiers, but, also, as *The Survey* so aptly puts it, "to civilize after the men have been militarized," to give hope and encouragement.

You are to hear at length from others along this line; sufficient for me to call your attention to the advisability of the proper care of this class if we are not to have many of them afflicted with "hospitalitis."

GENERAL CAUSES

I have spoken of the personal causes for hospitalism; now of the general causes. First, a patient may be in this general class because of social conditions, conditions which are beyond remedy by an individual, a hospital, or a class, but which require the combined action of all society. I shall attempt no solution, but shall simply call your attention to the fact.

The second general cause, and I am inclined to think an important one, is carelessness on the part of our staff, both visiting and house, perhaps in diagnosing the case, and in prescribing the treatment or in following the case after it leaves the hospital, the reason being, ordinarily, that the case is not interesting or the staff is inadequately manned or organized. Perhaps the staff man on service has too much work thrust upon him to give the individual obscure case the consideration which it deserves, and so: we hear, "Just a little bit nervous, that's all," or "He's been here before," buries the patient, perhaps literally. To illustrate the point, let me quote a member of this association, who says:

"The patient, a well-developed girl of about 18 years of age, had been confined to bed in various hospitals for about two years. She was not able to walk or even stand on her feet. An examination disclosed no physical disease. With the permission of the attending physician, the superintendent and his wife took the patient in hand. By patient work, at the end of one week she was able to stand by the side of her bed. She was given crutches, and at the end of another two weeks she was able to walk a little. At the end of the seventh week she was able to go shopping and to the theater without the aid of cane or crutches, and was sent to her home cured. Her 'hospitalism' was due to long confinement and lack of time for study of her case."

A third cause may be that the hospital lacks the facilities for establishing a true diagnosis, has no laboratory, no roentgen ray, etc.

It may also be true that the hospital lacks a follow-up system, and this is probably one of the largest causes for "hospitalism." It has, however, decreased within the past few years since the establishment of the social service worker, that important addition to the hospital's staff. Because of the follow-up system, the patient is now made to feel the hospital has a personal interest in him, and, instead of his seeking advice at another hospital, he returns to the place where he was given original treatment for further care and advice, until his complete recovery is established.

As an adjunct to the follow-up system there should be in every town of any size a social clearing house, where accurate information regarding every so-called charity case will be kept, available not for one hospital alone, but for all agencies at work; such, for instance, as that which is maintained by the Associated Charities in Cleveland or the Confidential Exchange of Information in Baltimore and in Boston.

Another general cause of "hospitalism" is the lack of cooperation between the visiting staff and the admitting officer of the hospital. Many a patient has slipped by the admitting officer because that officer has not demanded a definite diagnosis before admission or when the visitant desires admission for a patient to establish a diagnosis, the case is not followed up with promptness and a diagnosis required within a few days, and so the patient stays on indefinitely until finally it becomes a real problem how he can be removed from the hospital.

A sixth cause for "hospitalism" is a rank misconception on the part of the public generally as to the purpose of the hospital. "Why, Mrs. Jones told me to come here. She said you took anybody that felt sick." Publicity is needed to teach the ordinary citizen the real concept of

a hospital and the nearer that ordinary citizen gets to the actual working, the better.

That ordinary citizen can often point out to the complainant that it is not a hospital which is needed, perhaps, so much as fresh air in the sleeping room. In this connection, however, I would not minimize the value of expert advice to the magnification of ineffectual, amateur attempts at correction; I simply call attention to the fact that the public may and should help the physicians and the hospitals more than it now does.

TREATMENT

This is sufficient as to the causes, personal and general. Let us now speak of the treatment. A patient should be really cured while he is a patient in the hospital, not turned out hastily. If this is not practicable, then a patient should be followed into his home, or perhaps better, should be placed in a convalescent home to recover and come back to his normal condition in life.

I do believe the "follow-up system," as instituted in the social service department of our best hospitals, will mean much for the treatment of "hospitalism"; not simply to obtain a "cure," but to inspire where there was discouragement before, to bring sunshine and confidence into the midst of dreary surroundings and heart-breaking circumstances, "to restore respect to the downtrodden and prudence to the thriftless"; to lift the patient up to a higher plane of thinking, at least.

A third assistance in the treatment of such cases would be a complete out-patient department, where patients may return for post-discharge attention and possibly further diagnosis.

Another real assistance, suggested a moment ago, is that the public should be taken into the confidence of the hospital and given not merely dry statistics, but as much of the real work of the institution as it is possible to put into print. Put some flesh on the bones of those dry statistics in your annual report. Get out a circular letter regularly, a leaflet, a pamphlet and distribute them to the supporters of the hospital. Keep your expatriates acquainted with what is going on. They will take a pride in your work, will feel a personal interest, and will assist in eliminating the repeaters. Do not forget the local newspapers. Maintain their friendly interest, give them all the facts to which they are entitled and an interesting story now and then.

While I mention it last, I do not consider the value of a regularly appointed and accredited "spiritual doctor" or chaplain least in the treatment of the "hospitalitis" case. I do not mean that person of "D. D." appellation who baptizes the newly born and holds a religious service once each week, but that man of large experience with the world who has a firm hold upon life's great realities; who goes about the wards with infectious smile and kindly word of advice, lifting up the downhearted and centering the thought in a great faith, giving a reason for living an opportunity for service.

Whether poverty, real affection for the hospital, malingering, laziness, "case of nerves," poor staff organization, no follow-up system, inadequate facilities or lack of cooperation be the cause of "hospitalism," I am sure the use of modern business methods applied to the problem and the full use of available aids, such as the social worker, better mechanical facilities, closer relations between staff and executive, and perhaps a "spiritual doctor," will accomplish much looking to the successful *treatment* of such cases.

"HOSPITALISM" AND THE EMPLOYEE

Let us now turn very briefly to "hospitalism" in its application to our employees. We find it loses its flavor of undesirability—becomes a desideratum—and that, if it were not for the fact that our employees become attached to their work, see in it more than is represented by the pay envelope, become hospitalized, we would not be able to maintain the standard of work which is now possible.

I venture to say that, as a class, hospital employees, from the janitor up, can be outdone by no other class in loyalty and steadfastness of purpose. Yet the wonder is that so many are thus true when there is so little apparent organization, so little financial reward. The truth is we need hospitalized employees in these days of the high and often exorbitant wages paid by the commercial industries. We need those who possess ideals, who stick to their work for the love of it; and yet, if it is our good fortune to possess such an ideal lot of employees, is it not our duty to encourage them, to be careful of the routine of advancement, to make each position as attractive as possible and so place an incentive before every worker?

Our employees need training, not firing. Not long ago a prominent magazine made much of the "cost of firing," and it is true that we waste many thousands of dollars in this country because of the thoughtless "firing" of employees. We need better organization of our employees. Manufacturing concerns place foremen over groups and secure a definite division of responsibility. The workers are most carefully instructed in every detail. Compare this with that engineer who takes his orders from anyone in the hospital, that orderly who has never had a lesson as to how to lift or carry a patient, or the floor maid who, being told by the housekeeper to sweep the floors, is dragged off by a probationer to help clean a bed. Such rank carelessness in organization would show up in the lack of dividends in a commercial industry and would soon be banished, but in a hospital is simply charged up to the "terrible expense of caring for charity."

Let the head of each department carefully observe the employee's work. Perhaps by a slight change this work could be made attractive and the employee himself have been developed into a very valuable member of the organization. Let the superintendent herself or himself most carefully observe everyone upon the payroll, and perhaps there will be developed from that orderly your chief engineer, or from that hard-working, conscientious nurse the head of your surgical suite; perhaps from this maid your future housekeeper; perhaps from this little country girl, an expert seamstress.

There should be an interest instilled into the work of everyone. We have found an institution where the Taylor bonus system has worked most admirably. A certain wage is given for the work of that position and, provided that employee accomplishes a certain block of work in addition, a premium is awarded at the end of the month. If, however, the following month, the employee does not live up to the standard of the former month, 25 percent, perhaps, will be deducted from that premium; or perhaps an even larger block of work has been accomplished, then an additional premium is awarded. The money appeal is always very strong. Another way to secure interest is to post upon a roll of honor the names of all those who have not been tardy, have done their work well, and been courteous to everyone, or award a pin or badge for merit.

If foreign help is employed, classes in English and in American customs may be maintained by the hospital and this can be accomplished at very little expense by calling

for the assistance of the daughters of your board of lady managers, perhaps. For the female employees classes in sewing can be made a matter of profit to the institution.

Most hospitals *give* their employees treatment when needed. Would it not be better to have it understood that with the wage an insurance policy, as it were, is also given and the health of that employee is insured? Hospital care will be given if such is needed, not "free of charge," but because it has been earned by the employee. The same thing is true of the board furnished. Make the value of the meals understood; give meal tickets, which must be presented at each meal and punched. Then when comparing his position, dollar for dollar, with that in another industry, where the meals are not included, he will remember the value of his own position.

CONCLUSION

As we began by trying to define "hospitalism" in terms more or less clear, we conclude that "hospitalism" is an insidious disease, which may be one of the hospital's most expensive liabilities, although in these days of modern methods it should be turned into an asset for the community. When applied to an employee, "hospitalism" should be openly known as one of the hospital's greatest assets.

Acknowledgment is gratefully extended to the following for assistance in the preparation of this paper: Stewart M. Johnson, London, in "The Relationship of Poverty and Sickness and of Both to the Hospital," *THE MODERN HOSPITAL*, December, 1914, III, 351; Mr. Asa Bacon, Chicago; Dr. Thomas Howell, New York; Mr. Michael M. Davis, Jr., Boston; Mr. Daniel D. Test, Philadelphia; Dr. H. F. Chandler; Mr. C. B. Hildreth, Cleveland; Dr. John A. Hornsby, Chicago; Dr. Renwick R. Ross, Buffalo; Mr. P. W. Behrens, Toledo; Dr. Joseph E. Howland, Boston; Dr. Otto F. Ball, Chicago; Major Warren L. Babcock, M. D., U. S. A.

THE STANDARDIZATION OF HOSPITALS*

Reasons for and Against the Proposed Standardization of Hospitals—Faith System Versus Business System—The Former Allied to the Honor System

BY CHARLES A. DREW, M.D., Superintendent Worcester City Hospital, Worcester, Mass.

At the January meeting of the trustees, a communication was read and a questionnaire considered, coming from the American College of Surgeons, relating to a proposed standardization and classification of hospitals in the United States and Canada.

It may be worth while to review the reasons for the proposed "standardization" in the interest of a clearer understanding of this important project. It is alleged that, by reason of curable defects, the majority of hospitals are not doing the good work they should be doing. While it is granted that the small hospital of limited means cannot do all that can be done by the hospital with many beds and a large income, it is held that the defects do not correspond to size or always depend on poverty. Faulty organization, a poor equipment, and some other things are, it is claimed, more often responsible than is poverty.

It does not appear that the College of Surgeons is aiming at autocratic dominion. The college does not ask for legislative powers to coerce, and it professes to believe only in constructive and helpful criticism. This same project has been discussed by the American Hospital Association at several sessions, so that it is not a new subject to well-informed hospital workers. We fancy there are few who will deny that much good may grow out of this proposed standardization and classification. The argument runs something like this: The comfort and complete

recovery of the patients is of first importance. The advancement of the science of medicine and surgery, the teaching of interns and nurses, and the welfare of these student physicians and nurses while being taught are also very important considerations. No hospital that cannot make a fair showing in each of these important functions can expect to be considered a Class "A" hospital.

It is held that a fair judgment may be had of the work of a hospital by the care with which its work is recorded. Hence it is that case records count for much to credit or discredit a hospital.

It is alleged that only a few hospitals have an adequate "follow-up" system, without which no one knows how many of its discharged patients ever do fully recover. It is alleged that neither the managing board, the surgeon who operates, nor the superintendent in the average hospital is likely to know what happens to a patient after he leaves the hospital, unless he returns for further treatment.

It is charged that "we put young graduates into your hospitals as interns and nobody teaches them." "They are left to run at their own sweet wills, provided they don't get in the way of the machine—either the administrative or the medical machine, each of which rolls through the institution on its hurry-up schedule—and provided also that they (the interns) do a certain amount of routine work." "Nobody is responsible for their education." "They gather crumbs, as it were, from the rich man's table—chiefly the operating table! But so far as systematic training is concerned they do not get it." "If they 'learn by doing' either they've got to have critical guidance (teaching) or else the patients will suffer."¹

It is claimed that, in the majority of hospitals, many patients do suffer because the managing board requires almost no accounting from a member of the staff once he is appointed, and because the staff, speaking broadly, do not examine the work or the medical records made by the interns critically. It is claimed that this system—which might be called a faith system because based on the far-reaching quality of faith—is not businesslike, and as applied to hospitals, does not lead to "the substance of things hoped for"; nor is it likely to produce "evidence of things not seen." This may be said, however, that it is greatly to the credit of the young medical men serving as interns in hospitals run on the faith system that responsibility does usually stimulate eight interns out of ten to do good work in spite of a lack of systematic instruction. But there comes a time, too frequently, when the one or two of the ten become seniors and exemplars for younger interns. Then it is that the want of systematic and careful supervision works harm to patients and to the reputation of the hospital. It is among the counts of the indictment that the managing board of a hospital run on the faith system never drops a member of the staff, once appointed, until he has reached a fore-ordained age limit. It is also charged that no member of the staff ever recommends the release of an intern because of neglect of duty. This evidence of faith and charity seems to the critics too one-sided. They claim that too much faith and charity on one side gives the patient a "raw deal."

It is urged, by way of argument, that no business enterprise can hope for success unless the directors, either by personal examination or by proxy, keep in touch with the quality of the work turned out by the several artisans and experts whom they appoint to responsible positions. It is urged, further, that it is unreasonable to expect an intern to do his best in making records that he knows are not

*Presented, in abstract, at the February, 1918, meeting of the trustees of City Hospital, Worcester, here reprinted by courtesy of the *Boston Medical and Surgical Journal*.

likely to be read by staff or trustees, at least while he is connected with the hospital. It is claimed that a busy visiting surgeon, depending on an exacting private practice for bread and butter and means to support and educate a family, is not likely to spend the necessary time to organize and maintain a "follow-up" system which is pretty sure to lapse into desuetude as soon as the service is turned over to his less painstaking colleague. Hence it is argued that "it is as easy for a camel to go through the eye of a needle" as for a hospital to do its best work under the faith system of organization.

It seems that these reformers are not depending on theory alone; many of the propagandists have had practical experience. Many of them have had responsible positions as visiting surgeons or physicians to large hospitals. Some have had experience in trying to maintain a "follow-up" system and a teaching system, to see it lapse and all their efforts go for naught when the service changed. We may suspect that this campaign is inspired by the remorseful spirit of some departed surgeon, like Hamlet's father's ghost, "doomed for a term to walk the night and for the day confined to fast in fire." Perhaps! We cannot, however, find a scrap of evidence to support this fancy.

In all seriousness, it does seem worth while to know where we stand in the eyes of disinterested and competent critics. If a business system, with its checks and safety features, can be applied to professional work, those who trust in us ought, of course, to have the benefit of such a system. If the faith system is not the best system for the patients, of course, it ought to go. A business system is a system of checks and audits. A faith system applied to hospitals trusts that the superintendent and every member of the staff, once appointed, will do his best without any auditing or supervision of his work by the managing board. A business system insists that all the activities of the hospital shall be audited and a report made to the managing board at the board's regular meetings. The faith system, according to the reformers, is entrenched in the ancient castle of conservatism over the entrance to which might be written, "As it was in the beginning, is now and ever shall be." A business system owes no allegiance to a "slipshod" system because of the latter's honored lineage. The reformers insist that the end-product of professional work is quite as important as the economics of the hospital, and that the professional work will not rise to its highest level until it is audited, and followed up with regularity by a competent auditor or an auditing committee, which reports to the directors regularly.

Such are some of the arguments of reformers, voiced in different phraseology, from many sources. The reformers may not be all equally well informed; they do not agree in all things, nor do they all speak with equally fair moderation. Doubtless there might be something said on the other side.

The business system applied to professional work is of comparatively recent origin. Most of the progress in medicine and surgery for the past hundred years has been made under the "faith" system. We admit that much has been accomplished. "In spite of the system" the reformer retorts—but we know that the "honor system," much extolled by psychologists, is a near kin to the "faith" system. Under a sense of responsibility and honor, the best men do their best work, regardless of praise or blame. Stimulated by a sense of honor and responsibility, young men fresh from medical schools have done first-class work and faithfully written comprehensive, time-consuming records with no expectation that these records, with occasional exceptions, would be praised, blamed or even read by the chiefs of staff.

We know that it is not essential for a man to hold a professorship in a medical school to be a teacher, even a first-class teacher. We have such men on our own staff. In appointments and promotions, it may be true that the teaching qualifications have not been sufficiently considered. We have no sympathy with the idea, sometimes asserted or implied, that a municipal hospital is handicapped and must be handicapped by political considerations. When the trustees of a hospital accept and adopt the principle of a "closed" staff, they invalidate every excuse for inefficiency. Efficiency is the one adequate defense of a "closed" staff for a municipal hospital. When fifty men are selected from a profession numbering three hundred because of their supposed fitness, and given special privileges in a municipal hospital denied to the two hundred and fifty remaining members of their profession, they assume grave obligations, and the directors assume the responsibility of holding them to whatever system observation and experience prove to work out best for the patient. This, we think, will be accepted as a self-evident truth whether or not we endorse all the ideas approved by the American College of Surgeons. Whether or not any change in our own organization is recommended, we should dissent from any implication that a municipal hospital, *per se*, is handicapped by political considerations. Nothing in the history of our hospital warrants such an assumption. Nothing in the past tends to show that the people of our city do not want the best for their money. Nothing indicates that the citizens of any live municipality will fail to back the trustees in any move for the betterment of their hospital service—providing, of course, that the hospital has not been made to serve the political fortune of any city or hospital official.

While we believe this is the simple truth, we are mindful that medicine and surgery are not exact sciences. We realize that the temperament and constitution of each patient are important factors—often unknown quantities—in the equation. We know that it will require a broader judgment to audit professional work than it does to audit the financial activities of a hospital. And yet, the claim is made that it can be done without hurting any man unless it may hurt the feelings of the hypersensitive. How best and by whom may professional work be audited and results followed up is an interesting problem for each hospital.

The viewpoint of an able and sensitive surgeon, who has given years to the service of a hospital working under the faith system—which he regards as an honor system—may be different from that of the reformers. He may see no good reason why his time, much in demand, should be given to details plus the reading and criticising of case records. He may be willing to teach objectively, but not by time-consuming precept. He may feel that teaching, in its ordinary sense, should be left to those with adequate salaries—to those not dependent for an income on an exacting private practice. He may feel that the audit system cannot be fairly applied to professional work unless an auditor be provided endowed with omniscience. His experience with professing reformers may cause him to misjudge the campaign in prospect.

The American Medical Association, the Catholic Hospital Association, the American Hospital Association, and the Massachusetts Medical Society are enlisted for the reform as allies of the American College of Surgeons. Each organization has a committee to help the hospitals in the study and solution of the problems involved.

THE COMMUNITY HOSPITAL AS VIEWED BY A NURSE

A Texas Hospital, Seventy Miles Away From a Sister Institution, Which Does Original Research Work Besides Successfully Caring for Patients.

BY MARGARET HARRISON, Surgical Supervisor Kerrville Sanitarium-Hospital, Kerrville, Tex.

The Kerrville Sanitarium has been in operation for seven years. It is a semiprivate institution, originally built to meet the local demand, but, owing to the combination of complete equipment, excellent climate, and skillful staff, it is now attracting patients from a wide area.

The building, which was erected by the citizens of the

arranged that when desired one half of the building may be shut off and go unheated. This type of heating plant is very satisfactory in a climate with such a wide daily range of temperature, for much of the time when heat is needed at all, just a little to temper the atmosphere in the morning and after sundown is all that is required.

The building is provided with broad galleries so arranged that they may be used both summer and winter.

The octagon operating room has a skylight and three sides of heavy sanded glass, admitting north light. It is finished in white, and, in order to prevent the bad effects of glare, the surgeons wear the Mayo-Secor cap, with a beak as described in *THE MODERN HOSPITAL* of September, 1917. It is provided with a special ventilator to carry off



Fig. 1. The Kerrville Sanitarium-Hospital at Kerrville, Texas.

county, is of pebble dash stucco with metal tile roof and wide projecting eaves, a very practical construction for this climate. The inside walls are plastered with Keene cement, enameled to 6 feet above the floor and alabastined overhead. This allows the side walls up to 6 feet to be frequently washed. The floors are of asbestone with integral base. The centers are light tan, the borders and base are dark red. These floors have proved very satisfactory indeed; they are sanitary and very easily kept in first-class



Fig. 2. A view of the living room at the Kerrville Sanitarium-Hospital.

condition. We have found that an occasional light application of linseed oil and turpentine, half and half, followed by a coat of paraffine dissolved in gasoline, which, when dry, should be polished, keeps these floors in excellent condition.

The building is heated by two hot-air furnaces so



Fig. 3. The operating room in the Kerrville Sanitarium-Hospital.

the ether fumes. The surgical staff of the hospital places special stress upon preoperative and postoperative treatment, and the medical staff appreciates the value of the latest methods in therapeutics, so that the treatment rooms are equipped with hydrotherapeutic apparatus, electric-light bath, hot-air bath, electric vibrator, high-frequency coil, etc.

The nose and throat department is provided with fountain cuspidor, compressed air, cautery outfit, etc.



Fig. 4. A patient's room in the surgical department of the Kerrville Sanitarium-Hospital.

The laboratory and drug room are well equipped and presided over by a salaried house physician.

The hospital has an endowed library of over a thousand especially selected volumes. This has proved of the greatest value and is a source of constant pleasure to the patients.

The building is so arranged that all surgical work is cared for on the second floor. The first floor is devoted to convalescents and medical cases, where they will be away from the odors and noises incident to the surgical department.

The whole second floor is furnished in the best grade of white enameled steel furniture. The bedside tables have plate glass tops with a compartment below for utensils. The beds have attached adjustable back rests. With the composition floors, the enameled walls, and the enameled steel furniture, the equipment of the surgical department makes the most efficient service possible.

In the rooms of the medical department on the first floor, oak and mahogany furniture is utilized, hot and cold water is provided, and an endeavor is made to make the rooms homelike without doing violence to the essential sanitary features.

This institution seems to us to approach the ideal in community hospitals. It is large enough to support a complete equipment and to make it practical to employ competent help in every department including a house physician, and yet not so large but that one chief of staff can keep in personal touch with every detail. The chief of staff is a Fellow of the American College of Surgeons, who naturally takes pride in keeping it fully abreast of the times. It is self-supporting and provides for both charity and pay patients. Careful records are kept which answer the questions: What was the matter with the patient? What was done to him? What was the end-result?

During the past seven years members of the staff have made a number of original contributions to both medicine and surgery, such as, "An Improved and Simplified Technique for Autoserotherapy," "The Treatment of Pellagra by Autoserotherapy," "Glucose Solution by Hypodermoclysis for the Prevention of Postanesthetic Acidosis," "An Improved Hemorrhoid Operation," which Dr. J. B. Murphy said he considered a "distinct advance," and a number of improvements in surgical instruments.

Thus it is seen that even though a hospital is isolated—over seventy miles from a sister institution—with proper equipment and competent men on the staff, it may not only do the regular routine work that comes to it, but also reach out into the promising fields of research and improvement. The satisfaction gained by the staff in maintaining a standard that will produce these results more than repays them for the effort.

Our Eastern Representative

In regard to Mr. Joseph J. Weber, who this month begins his duties as Eastern representative and field editor of THE MODERN HOSPITAL, the S. C. A. A. News prints the following:

"Joseph J. Weber, who has been the efficient secretary of the committee on hospitals of the State Charities Aid Association for the past three and a half years, has resigned to accept the position of assistant director of the Boston Dispensary, and Eastern representative of the magazine, THE MODERN HOSPITAL. His resignation is received with regret by the association.

"Mr. Weber brings to his new position a splendid equipment of training and experience. He is a graduate of Hamilton College, from which he holds the degrees of B.A. and M.A. He prepared for social work at the New York School of Philanthropy. After graduating from the school he became director of the Civic Association of Englewood, N. J., and came from there to New York as financial secretary of the Charity Organization Society, a position which he held for two years. Since then he has been with the State Charities Aid Association.

"Among the more important activities of the hospitals committee while he was its executive officer have been the following:

"The formulation of a report of a survey on sickness in Dutchess County and the organization of a comprehensive public health association in that county which is likely to serve as a model for other counties.

"Making community surveys of hospitals in Westchester and Washington counties to aid in the increase of hospital facilities in both counties.

"An extensive study of the facilities in general hospitals and dispensaries of New York State outside of New York City for the diagnosis and treatment of venereal diseases.

"A critical study of plans of various new hospitals in New York City and elsewhere.

"Compiling a handbook on the care and treatment of alcoholic and drug addicts.

"During the past year Mr. Weber's services have been loaned on part time to other organizations for important pieces of work. He acted as secretary of the committee on planning and financing of municipal and nonmunicipal hospitals of the 1917 annual meeting of the American Medical Association and as such had charge of the organization and preparation of its first extensive exhibition of hospital plans.

"Since April of last year he has acted as secretary of the New York Mayor's Committee on Hospital and Medical Facilities, a position he now relinquishes. This committee has assisted in important war work in connection with the organization of adequate hospital, medical, and nursing facilities for military needs in and near New York.

"Mr. Weber has delivered addresses on health topics at public hearings before boards of supervisors, committees of the legislature, county medical societies, and has also been one of the outside lecturers before students of Teachers' College at Columbia. He has written numerous articles for hospital and health periodicals."

"Treat Thy Nurses Sweetly"

The following extract, taken from Jeremy Taylor's "Holy Dying," is so quaint, so instructive, and takes such an unusual view of the position of a patient towards her nurse, that we are sure it will be of special interest to our readers: "Treat thy nurses and servants sweetly, and as it becomes an obliged and a necessitous person. Remember that thou art very troublesome to them; that they trouble not thee willingly; that they strive to do thee ease and benefit, and are glad if thou likest their attendance; that whatsoever is amiss is thy disease, and the uneasiness of thy head or thy side, thy distemper or thy disaffections; and it will be an unhandsome injustice to be troublesome to them because thou art so to thyself; to make them feel a part of thy sorrows, that thou mayest not bear them alone; evilly to require their care by thy too curious and impatient wrangling and fretful spirit."—Nursing Mirror.

The Old Time Doctor

Out of the past that was kind and warm,
Comes, with a scent of iodoform,
Mixed with a hint of valerian,
The dignified, old-time doctor man,
Beard that is long and streaked with gray,
With smile that is grave and a solemn way.
With ear that is keen to my mottled skin
To hear what is wrong with the works within,
I felt that he got more honest dope
Than the modern man with his stethoscope.
His long-tailed coat, I can see it yet.
His calf-skin boots I cannot forget.
With saddlebags and high, silk hat,—
There are no more men in the world like that.
But out of the past that was kind and warm
He comes with a scent of iodoform.

—Illinois Health News.

THE MEMOIRS OF A HEAD NURSE

II. Bill Black, the Best Orderly I Ever Knew—How John Barleycorn Handicapped a Life of Usefulness

We had an orderly in the emergency service, old Bill Black. Bill was a born orderly, and there are not many of his kind. You know the usual lot, the floaters, the men who have failed in most everything else, and who work long enough to get some new underclothes and an overcoat and have enough left for a spree. We had a lot of these coming and going, but Bill always stuck. He was an orderly and nothing else. Hospitals were home to him and he couldn't exist in any other place.

Bill had been a British soldier—had served his time in the army in India—and he knew more about treating heat prostration cases than the staff and the interns all put together. I'll never forget one summer we had in D., when there had been a horrible heat wave that lasted several weeks. The temperature in the operating amphitheater under the glass roof seldom went below 110 or 115 in the middle of the day. Every once in a while a nurse would topple over, and we fed everybody cool drinks through glass tubes put through their masks while they were operating.

The police ambulance kept up a steady run. Most of the patients were teamsters or street laborers or kitchen workers, unconscious with heat; later on their temperature would run up toward 107, and they would go mad. It was then that Bill would get in his good work, and we would have to lend him to the men's wards, with another little Englishman we had who had seen service in India. The staff men and the interns would leave their orders in the ward and tell the head nurse to "leave it to Bill."

I'll never forget how Bill and his pal worked over one giant teamster, who had been brought in unconscious and with a temperature so high that you could not believe the thermometer. He had become so wild that they had to strap him in bed, and when Bill was called in council the staff man who had the case said the patient was a goner if the temperature didn't come down, and he didn't think it would with that powerful maniac fighting treatment the way he did. But, fortified with four ice-caps, four hot-water bags, a foot-tub full of cracked ice, plenty of sheets, an electric fan, an enema can, and a long feeding forceps, Bill started in. With the assistance of three interns and the other orderly he succeeded in giving the patient a cooling enema, and wrapped him in cold wet sheets, underlaid with plenty of tightly fastened rubber sheeting, ready for the coming battle. And battle it was, this maddened giant and death on the one side, and Bill and the other orderly, Harry Carnes, fighting for every inch of ground on the other. On went the electric fan.

"Full speed, 'Arry," said Bill, then with both hands full of crushed ice Bill would go over the wet-sheeted body of his patient, talking all the time as you would talk to a sick child or a horse that had been frightened. "Steady boy, take your drink now; that's the lad; try it again." And 'Arry was upon his spare time he had when not sitting on the patient to keep him down, to feed him pieces of cracked ice on a long forceps. Then the tide would turn, and Bill would call out, "'Is 'ands and feet is too cold; come on with yer 'ot-water bags; off with yer fan, she's comin' down too fast; quick 'ere with yer dry shirt."

And so, sometimes for hours, they would fight the fever until they had conquered it. And when the patient, weak as a kitten, but sane and saved, would fall into a natural

sleep, Bill would say, "Come on, 'Arry, I guess 'e's safe now to leave to the doctors." Then the men would saunter back to their work, soaked to the skin, and gray faced with exhaustion, but smiling and content with the victory won.

Every two months or so Bill simply had to get drunk, never on duty, however, as a rule he didn't lose any time by it, but gloriously drunk he had to get, and in their attempt to get him to bed and save his job for him, some of the other orderlies usually wore a black eye and numerous bruises after each of these occasions. Once in awhile he would have to lay off the next day, and then the details of Bill's last offense would get to Dr. B., the superintendent, and Bill would be fired. Dr. B. would pound his desk and say, "Now this is the last time, nobody need ask me to take him back again, because I won't do it; he's a disgrace to the place. Never again."

Well, in a day or so there would appear a very humble and contrite Bill. He'd sneak up to the superintendent of nurses or the operating supervisor, and twirling his hat in his hands would begin the same old question. "Do you think, now, if maybe you would talk to the old man, maybe I might get another chance?"

The operating room supervisor would say, "I don't know, Bill, here you left me on a big clinic day, with thirty major operations and all the police ambulances in the city rushing in wrecks, and the other boys trying to do all the work alone, and the only help I could get a dub of a ward orderly who didn't know the morgue litter from a stretcher cart—but you wait around down in the basement, I'll see the doctor and see what I can do."

And then the following dialogue would take place in the front office, after the supervisor had gone down, apparently for something else entirely, and during the course of a conversation begun on an entirely different subject:

O. R. Supervisor: "I'm having a pretty hard time with the orderly question upstairs."

Superintendent: "That so? What's the matter?"

O. R. Superintendent: "You know we are having an unusual rush up there now, and there is more than the two men I have can do."

Superintendent: "Well, can't you get another one?"

O. R. Supervisor: "Oh, yes, I've tried two or three ward orderlies, and none of them are any good. [Long pause.] I wish we could get Bill back. He can do two men's work, and he knows as much about the service as I do."

Superintendent: "That ———, I'll not have him in the building."

O. R. Supervisor: "But you know that there is to be a big celebration in the city next week, and there will be crowds and a lot of accidents, and——"

Superintendent: "Oh, well, you women will get your sympathies worked up. If you really need him, go get him; I suppose he is hanging around somewhere."

O. R. Supervisor: "Thank you, doctor, I think I can find him."

And the word flies to the basement that "all is well."

The first hospital exclusively for desperate cases, operating as a field unit, is an American medical corps hospital within range of the enemy guns in Picardy, says a press dispatch. Four American nurses there probably are working closer to the front than any other women in the entire allied lines. Unworried by air raids and bombardments, their only concern is that "the gas masks are too big for our noses."

VISITORS AND VISITING IN HOSPITALS*

The Problem in the General Hospital—Desirability of
Restricting Visiting in the Wards—Less Protection
Required for Private Patients—The Varying
Problems Presented by Special Classes
of Hospitals

By JOSEPH GEFFEN, Superintendent Mount Sinai Hospital,
Philadelphia.

Conditions vary to such an extent in different hospitals as to make it impractical to lay down set rules concerning visiting and visitors. In the course of an extended inquiry and investigation, the fact was clearly disclosed to me that the rules and regulations governing the admission of visitors to patients undergoing treatment in hospitals are so nearly alike as to lead one to believe that practically all have been copied from one and the same model, and that, by some tacit understanding or misunderstanding, it has been agreed upon that none should introduce a change even though all will unhesitatingly agree that changes for the better in that direction are sorely needed.

I was, therefore, prompted to write this paper, not because I can individually bring about radical changes or revolutionize the field, but in the hope that universal discussion may bring about certain changes, and ultimate betterment to justify this humble effort.

All will agree that hospitals are first and foremost for the treatment of the sick, but since the question of visitors and visiting is so closely interlinked with the care of patients in the hospital, the problem becomes very complex and calls for extraordinary judgment to determine if visiting can be entirely eliminated, and if it would serve the best interest of those who should receive our primary consideration, or if it can be partly mitigated by striking the happy medium. Due consideration of this subject, however, makes it clear that total elimination of visitors is neither practical nor possible. First, it has been proved that the mental anxiety of the patient, because of total absence of visitors, would be a retarding factor in the progress towards recovery, and secondly, even were this not the case, public opinion, upon which every institution so greatly depends, would be hopelessly against it, not only to a point of withholding financial support, but to a point of impairing the institution's usefulness, for it is safe to say that few would enter our wards with the prospect of being utterly secluded from their relatives and friends. Admitting, then, that visitors must be permitted, we will confine ourselves to the discussion as to the way in which it can best be done and how we can best serve the interest of both the patient and visitor.

THE GENERAL HOSPITAL

The Wards.—Undoubtedly the greatest problem of visitors is encountered in our large general wards; we are often obliged to refuse visitors to a patient whose condition is such that visiting would be detrimental to him, and yet all around this very patient are visitors whose loud speaking and commotion is often more unbearable than would be a relative who perhaps would be content to stay only a few minutes. It is true that, when possible, patients in a serious condition are removed during visiting hours to some room provided for that purpose, or a screen placed around the patient, but the former is not often possible or practical, because by removing him the patient's suspicion is aroused and unduly excited, and to place a screen around the patient is overcoming the difficulty to

a very small extent. It would, therefore, seem advisable to restrict visiting to the general ward patients as much as possible and practical.

Length of Visit.—Most institutions permit visitors to the general wards three or four times a week, and allow them to stay from two to four hours, thus causing an unrelieved strain upon the patient. While conditions impose upon us the necessity of allowing visitors three times a week, it does not appear to be absolutely necessary that the time for visiting be prolonged to the period generally allowed. I feel that the reduction of time limit to one hour would serve the best interest of the patient and at the same time would cause less inconvenience to the institution. Let us consider the practicability of the one-hour limit and the benefits that would accrue therefrom.

It is quite obvious to anyone familiar with those visiting patients that the object of their visit is based chiefly on their anxiety about the patient's physical welfare. The conversation, therefore, should naturally be confined to that subject, and, if the average visitor would limit himself to the essential questions that are the purpose of this visit, it would not be necessary for any one visitor to stay more than fifteen or twenty minutes, thus affording an opportunity for at least three friends to visit during the hour, even though only one is allowed at a time, and at the same time minimizing the danger to the patient caused by unnecessary talk of visitors who have more than the above-mentioned time at their disposal. It is a fact that the more intelligent usually make their visits to the sick very brief. Viewing the question from a material point of view, we cannot disregard the inconvenience caused by suspension of many activities, both medical and institutional, for a duration of two or more consecutive hours.

Number of Visitors.—The question how many should be permitted to the bedside at one time and the number that should be allowed during visiting hours is quite worthy of our consideration. Most hospitals permit too many visitors to see patients during visiting hours. Very often as high as twelve people will visit one patient. This custom does not serve the best interests of patients because this constant stream of visitors is too great a strain not only upon the patient visited, but also upon those in the same ward. There seems very little reason why more than two or three people should be allowed to see a patient in one day. Further to minimize the patient's discomfort, would it not be advisable to allow only one visitor at a time to the bedside of the patient, thereby relieving the patient of the strain of having to listen and talk to two at one time, which is often the case under the present system? Furthermore, it would reduce the noise created by the visitors, since only half the number would be in the ward at one time.

Visiting Hours.—Most institutions confine their visiting hours to the day time. This, I believe, is an injustice to the relatives of the sick, because, when visiting is permitted during the day hours only, there are many who must be either deprived of the privilege of seeing the sick or compelled to leave their work; hence it would be advisable to make one visiting hour in the evening. I am fully aware of the fact that the sick are usually worse at night, and for that reason visiting should be confined only to members of the family who cannot come at any other time. Some are against night visiting on the grounds that there are fewer nurses on duty at night and therefore there will be less supervision; on the other hand, while a greater number of nurses are on duty during the day hours, those

*Read before the American Hospital Association at its nineteenth annual session, Cleveland, Ohio.

nurses are just as busy and have no more time to devote to visitors, so this objection has very little weight.

Private Wards.—The problem of visitors reduces itself in proportion to the decrease in the number of patients in a given space. This is why we find it more practical to allow a greater latitude to visitors in private wards. However, a one-hour daily visit should be sufficient.

Private-Room Patients.—In dealing with the private-room patients the problem is very easy of solution, since those visiting private rooms do not interfere with the welfare of any other patient. Therefore, visitors can be allowed nearly all day. The only thing that should be required of those visiting private patients is that they should be obliged to inquire in the office before going to the room of the patient; and, if for any reason the patient does not care to receive visitors or his physician has ordered that none be permitted, it will be but a simple matter to keep visitors out.

SPECIAL HOSPITALS

Children's Hospitals.—There are, of course, certain well-defined disadvantages to the visiting of children. The danger of transmission of contagious diseases has not only been attributed to visitors, but, in some cases, has been fairly proved. We all know that as soon as the child sees its parents it begins to cry and will often continue the performance until some time after they leave. This condition is by no means a healthful one, very often being the cause of rise in temperature and a feeling of homesickness and restlessness. Furthermore, we cannot overlook the danger of food being smuggled in and given to the children with ill effects; in short, there is little room for doubt that visiting is practically always detrimental to the physical welfare of the child, and yet, with all its disadvantages, I doubt whether we can exclude parents from visiting their loved ones. From personal experience in a hospital that does not permit visiting to children, I know that, when the mother is told that she will not be permitted to visit the child, in many cases the patient was either taken to another hospital or cared for at home. Furthermore, a feeling of resentment will be engendered against such a hospital and its usefulness will to some extent be curtailed. We can and should, however, in justice to the patient, limit these visits to once or at most twice a week. No one should be permitted to enter the children's ward without putting on a visitor's gown, preferably the kind that is slipped over the head and very long, making it somewhat difficult for the visitors to use their hands.

Maternity Hospitals.—Visitors to maternity cases should be treated in much the same way as those in hospitals for communicable diseases. The most rigid asepsis should be observed by the use of caps and gowns and under no condition should visitors be permitted to touch a parturient woman, either before or immediately after confinement. On account of the nervous condition of the patient for at least twenty-four hours after confinement, visiting should be restricted to mother or husband of the woman; sometimes, owing to infection or other complications, it may be wise to continue the restriction for a longer period, but in the ordinary case, the sooner a woman is permitted to see those who are near and dear to her, the more rapidly she will recover her normal spirits. Under no condition should the visitor be permitted to handle the infant.

Hospitals for Contagious Diseases.—It is a fact that many children suffering from a contagious disease are treated at home for the sole reason that parents prefer to be isolated with the child and are willing to undergo

hardships rather than send the child to a hospital in which the patient cannot be seen, except the patient be in a serious condition. But since these hospitals until the present have not yet given due consideration to visiting by building the institution in such a manner as to make it possible for visitors to see the patient without coming into dangerous contact with them, there is little room to doubt the wisdom of excluding visitors. In Germany some hospitals for contagious diseases have so built their institutions as to make it possible, by means of glass partitions, for visitors to see the patients without coming into contact with them. It is hoped that our institutions will adopt some similar plan of architecture providing for visiting to this class of patients without danger of contact.

Tuberculosis Sanatoriums.—Tuberculous patients in sanatoriums, being as a rule physically fit to walk about and mentally alert, will naturally dwell upon their affliction, which most certainly will have a deleterious effect upon their vitality. It would, therefore, seem to be advisable to encourage visitors as frequently as would be practicable, in order to divert the mind of the patient from his illness. But considering the nature of the disease, particular care and supervision should be exercised over these visitors. It is a familiar fact that these institutions, unlike hospitals, usually cover a large area, and if its visitors be permitted to meet patients all over the grounds, as is often the case, there is more harm than good to be expected to both patient and visitor. For instance, unless closely watched, a visitor in his ignorance may smuggle in to the patient food that is strictly forbidden; on the other hand, out of great solicitude, the visitor himself, being blind to the danger of close contact, will sometimes, upon leaving, kiss the patient.

VISITS OF OUTSIDE PHYSICIANS

In some hospitals with closed staffs there is clearly indicated a desire on the part of the management either to exclude outside physicians as visitors or so to surround their admittance with red tape as to cause them the greatest amount of inconvenience. Frequently the rules prohibit outside physicians from visiting ward patients unless accompanied by the intern. It is, of course, a courtesy to detail a house physician, but to prohibit the visitor entering the ward without the intern is very annoying and certainly does not inculcate a spirit of respect for or cooperation with such a hospital. It should be remembered that the family physician is often the family advisor and that, even though his professional skill may not equal that of the hospital staff, he is in a position to either help or harm the hospital by either favorable or adverse criticism. The best and most lasting results to the patient can be attained only by cooperating and consultation with the family physician of free patients, and even by the further expedient of permitting him free access to the hospital whenever he desires to enter. He should also be permitted to inspect the clinical charts; the refusal to grant such rights can only be considered as an admission that the records of the case are incomplete or that the case has been carelessly reported. Then, again, the hospital is performing one of the most important functions by allowing the outside physician to study the records of medication and treatment; it assists in the education of the doctor.

REGISTRATION SYSTEM

Much depends upon the size of the hospital and the number of visitors allowed to one patient in determining the best method of handling and controlling its visitors. Having studied the workings of many systems, I am led to the

conclusion that the best method, and one suitable for almost every institution, is one adopted by the Michael Reese Hospital of Chicago and described in *THE MODERN HOSPITAL*, which is the following:

A board is set up at the desk in the main hall, where visitors must receive their credentials before going into the hospital proper. On this board are figures representing all the wards of the institution, and beneath the number of the ward are small pockets made of vulcanized rubber or some such material, the number of pockets for each ward corresponding to the number of beds in the ward, and in each of these pockets are three cards; one projects above the other two and contains merely the name of the patient occupying the bed. In front of this name card and a little shorter, so that they do not hide the name, are two other cards, the regular visitors' cards apportioned to the patient written lightly in lead pencil so that it can be easily erased for use of the card elsewhere. It is the practice to allow two visitors only at one time and when the two cards apportioned to the patient have been distributed to visitors no other visitor can see the patient until the cards are again returned to the board, as evidence that the visitors have gone. If it is ordered that the patient shall have only two visitors during the day, the cards will not be returned to the rack until night. If the patient can have as many visitors as choose to call, the cards are immediately returned to the rack on their surrender by visitors as they leave, and they can be given out to other visitors. Sometimes, by the order of the doctor, the patient is not to have any visitors at all, and in such case a note to that effect is stuck in the pocket against the patient's name, so that visitors may be refused when they present themselves. Sometimes it is necessary for the business office to see the friends of the patient for financial or other reasons, and in that case a note to that effect is slipped into the pocket against the patient's name, so that if anyone calls to see the patient he can be sent to the office; or perhaps it is the house physician who wishes to see the friends of a patient to present some problem or make some announcement, and the note in the pocket will request that the house physician be sent for when a visitor comes.

There is no doubt that it is the desire of the management that all visitors should be treated with every courtesy and consideration, but I doubt whether this hope is fully realized, because the duty of handling visitors is usually delegated to a young clerk who possesses very little judgment and is usually not overfilled with the milk of human kindness. The success or failure of the handling of visitors is not so much the system as it is the individual in charge. There are few, if any, more important duties than the handling of visitors, since it is the best means of establishing a friendly relationship between the public and the institution. A kind word will often do more to establish the reputation of the institution than the best medical skill. It is, therefore, advisable to choose carefully the person to whom to entrust this most difficult duty. In my opinion a senior nurse or even a graduate would best be fitted to take charge of the visiting desk. Not only would a nurse be able to understand more intelligently the doctors' orders in order to transmit them to the visitor, but her uniform itself places her in a position to command respect, which the average clerk would find it very difficult to get. Furthermore, a nurse could become intelligently informed regarding the condition of the patients, and, in the event that the resident physician is too busy to answer questions of the anxious relatives regarding the condition of the patient, the nurse undoubtedly,

with the physician's approval, could readily act as his substitute with entire satisfaction.

LOOKING FOR BRICKS

The Children's Home at St. Anthony, Newfoundland—A New Building Badly Needed for Newfoundland Orphans

When Dr. Grenfell found little children along the Labrador suddenly orphaned, without relatives or friends to take care of them, he set to work speedily to build them a home. He built them the best home that could be built, with the materials at hand. Unseasoned lumber had to be used because there was no other; the building



Fig. 1. Nine-year-old Tommy Shuglo, who came to the Children's Home when four years old. Though very delicate and often sick when he first came, Tommy was such a pet that his favorite expression was, "I likes everybody, I do."

season is short in Newfoundland, and the children were waiting. Before long there were more children waiting and no room for them, so in the midst of many other interests and needs, additions were swiftly built to the original home to shelter the homeless. For fourteen years the children have found there a welcome so warm and a



Fig. 2. The present children's home at St. Anthony, Newfoundland.

care so constant and tender that they have grown well and happy. The house is getting old and draftier, and more inconvenient to repair. A new home, which must be of brick, is badly needed. Each brick costs twenty-five cents by the time it is laid at St. Anthony, and the sending of twenty-five cents for one brick entitles the sender to membership in the Grenfell League and to a Grenfell League button. Contributions may be sent to Miss S. E. Demarest, 156 Fifth Avenue, New York.

You will confer the greatest benefits on your city, not by raising its roofs, but by exalting its souls. For it is better that great souls should live in small habitations than that abject slaves should burrow in great houses.—Epictetus.

Who Should Be Dispensary Patients?*

By MICHAEL M. DAVIS, JR., Ph.D., Director, Boston Dispensary, Boston, and ANDREW R. WARNER, M.D., Superintendent, Lakeside Hospital, Cleveland.

There is a hoary misconception concerning the meaning of "charity." Formerly it was generally conceived as a dole to the destitute. Unless the recipients were unable to make any return except in gratitude, the gift was hardly charity at all. But the modern conception of charity is not a dole, but a service—a service rendered by an individual, an organization or a community to persons or groups who could not otherwise obtain the benefit provided.

Ability to obtain a benefit depends partly on the income or opportunities of the recipient and partly on the cost of the thing to be obtained. Now the cost of medical service supplied by dispensaries has changed greatly since the early dispensaries began their work, and especially during the last fifteen years.

The old dispensaries provided merely the advice of a single physician and medicine. They corresponded to the general practitioner before the days of modern scientific methods of diagnosis. The modern dispensary provides varied and expensive services, and what it offers its patients is to be compared not only with the service of the general practitioner, but with that of the specialist, the laboratory, or the x-ray man.

A very little consideration of the cost of treatment of different diseases shows within what wide limits this ranges. A minor illness might require a couple of office visits to a general practitioner and a little medicine. All this might cost a patient \$2.50 or \$3.50.¹ A case of "indigestion" requiring several examinations, x-ray and care for a considerable period might cost, at a low estimate, \$75 for the first six months. A case of syphilis requiring spirovarsan injections would cost over \$100 for the same period. Examinations of the nose and throat by a specialist and operation for a deviated septum, with the necessary aftercare, would cost \$50 or over. Examination of the eyes by an oculist, with provision of glasses not unusually expensive, would cost \$10. The supervision of a little baby subject to digestive upsets might cost \$40 to \$60 within six months. The diagnosis and supervision of a case of adult tuberculosis at home would cost \$25 to \$30 during the same period, not including the expense of special food. Complex conditions requiring examinations by a number of different specialists, x-rays, and various laboratory tests might cost \$100 or \$200 before the diagnosis was reached.

Thus the test for the charitable dispensary is not the ability of the patient to pay "a medical fee," but to pay the medical fee required for his particular case at the usual rate charged by competent doctors in his community. In other words, cost of service needed, in relation to the financial ability of the patient, is the real test.

The broadening of the range of dispensary service medically has thus greatly broadened its scope with respect to the economic classes in the community. The widely varying kinds of medical and surgical work which now can and should be done, and their widely varying cost, explain why even the charitable dispensary cannot confine its work to any particular economic and social group at the lower level of the community. The higher paid wage-earners and the small-salaried groups need its services, particularly in the specialties and in difficult cases requiring elaborate consultation and special tests.

The more developed the medical organization of a dis-

pensary is, and the higher the reputation of its medical staff along their various lines, the more surely and the more justly will this institution draw patients from varied classes in the community. Many of the patients may be able to afford ordinary medical fees, but need, and feel they ought to have, special service which they could in no way afford to pay for at private rates. This consideration applies particularly to the teaching dispensary attached to a medical school of high standing. Such a dispensary may well fill more than a local position as a center for diagnosis and consultation as well as for treatment.

FEEES FROM DISPENSARY PATIENTS

The antiquated conception of charity to which we have referred is responsible for another misconception, namely, that the services of an institution like the dispensary must be rendered without price. There still exist those who wish to give their charity straight; those who see no distinction between the medical service provided by a hospital or dispensary and the pair of shoes or "grocery order" furnished by a relief society. The gradual passing of this point of view is evidenced by the fact that a majority even of the charitable dispensaries of this country now charge small fees for admission, treatment or medicine, or for one or all of these. There has been, however, little discussion of the economic and moral foundations of the fee system in dispensaries.

It is obvious that, whether a dispensary is founded as a charity, for teaching, or for public health service, it must not charge a fee based merely upon the cost of the service rendered, for in many instances this fee would be too high to help many of those who need it, and the institution would thus defeat its purpose of service. On the other hand, practical experience of dispensaries, as well as an unprejudiced consideration of human nature, bears out the belief that those who pay something, even ten cents, for what they receive take advice or treatment more seriously and feel rather better about accepting the service than if they paid nothing. Most people are built this way. Some are different. The dispensary fee system, however, is justly based upon the psychology of the majority.

There is another point of view, namely, that services like the dispensary, providing health for the people, ought to be supported by general taxation and be free for all citizens. Whether or not this point of view is sound, most will agree that until medical service is a state function (if that day comes), a dispensary, as a form of medical service, ought to conform, in the general principles of its operation, with the general system for providing medical service in the community. From this standpoint there is no reason why dispensaries may not, on the one hand, be private enterprises like the Mayo Clinic, or, on the other hand, be charitable institutions. They correspond in the one case to a private school, in the other case to an endowed college. In either instance there is no reason why they may not charge fees.

What shall be the relation between the patients of a physician in a dispensary and in private practice? Should patients who can pay the usual private fees for the needed medical service be treated in a dispensary free, or for nominal fees? If such persons apply at a dispensary for treatment, shall they be referred to private physicians, and in particular to the staff of the dispensary itself? What shall a physician do when a patient in the clinic seems to be in sufficiently good circumstances to pay private office rates? For the protection alike of patient, physician, and dispensary, it is necessary to establish a policy and devise a procedure by which the selection of patients able to pay

*Extract, reprinted by permission of The MacMillan Company, from a forthcoming book on "Dispensaries: Their Organization and Management" by the authors above named.

¹It will be obvious that these statements of medical cost are merely illustrative. They are based on what physicians or specialists would probably charge patients known to be of very moderate means.

private fees shall be made by the dispensary, and the patients themselves be referred in a manner which will be likely to insure them good medical treatment, be just to the medical profession, and beneficial to the community.

The policy which should govern the situation may be set forth in a few simple rules:

1. A charitable dispensary aims to provide the best medical treatment for those who cannot otherwise secure it. It aims not to accept patients who can afford to pay the usual private rates for the medical care which they require.

2. The admitting officer of the dispensary, under its superintendent and trustees, should be responsible for determining the circumstances of the patient and, after consideration of the patient's income, family responsibilities, and the probable cost of the medical treatment required, for deciding whether the patient should be treated in a free clinic, a day clinic, or in the private office of a physician.

3. The reference of the patient to the proper agent for treatment should be made by the admitting officer, or other administrative official of the dispensary, not by a member of the medical staff.

4. Due records should be made of each case thus referred for treatment outside of the dispensary.

5. No physician should solicit private practice from patients.

In carrying out such a policy effectively, the chief requisite is a well-organized admission system, under a competent head. Most of the difficulties which arise are due to a lack of this. The medical staff must be fully informed of the policy. They should understand that, should a patient appear in a clinic whom a physician thinks has not been properly judged by the admission desk, the patient is to be sent back to the admission desk for reconsideration and further reference. The question then arises, to whom shall the admission desk refer a case needing private treatment? In general, it seems just that such a patient be given the names of one or more members of the staff of the clinic to which his disease would naturally assign him. Cases also arise in which the patient asks at the admission desk for the name of a competent doctor, or himself solicits a physician, in the clinic, for private treatment. When a patient does this the physician should report the fact to the admission desk, or to the representative of the admitting officer in the clinic (the social worker, nurse, or clerk). The admitting office or its representative will then refer the patient to the physician, but due record will be made of the fact upon the patient's record card and elsewhere. Solicitation of private practice by physicians in clinics should be regarded by the administrative authorities of the dispensary and by its medical staff as seriously unprofessional conduct.

What shall dispensary fees be, how much and how determined? They should clearly follow the traditional ethical rules of the medical profession, "not refusing service to anyone really needing it, whether the fee levied can be paid or not." But how shall the general level of the fees be determined, understanding that partial or complete remission of fee will always be made in suitable cases?

In private medical practice the fee received by the physician is partly a compensation for his medical service and partly payment for the expenses he must meet in maintaining his office, his assistants, his equipment, automobile, etc. In the medical institutions the appliances, instruments, laboratory, nursing, etc., are provided for the doctor. When a dispensary not organized for profit does not pay its physicians, it may charge fees not averaging more than the cost of the services rendered, excluding any charge for the medical service as such. Were this principle strictly carried out, the physician giving his time in

the dispensary would receive no money, and the fee paid by the patient would no more than meet the strictly administrative expenses. These, on the average, would be less than those required to maintain an equivalent medical service in a single private office.

If fees at a dispensary are on the average higher than the administrative costs, then the clinic becomes a pay clinic and the amount of the fees received above the administrative costs should go to the medical profession, either directly in salaries to the staff, or in some fashion approved by them for the advancement of medical science or medical education. In practice the usual rates of fees in the charitable dispensaries of this country at the present time cover from one-fifth to one-half the administrative cost.

SUMMARY

The principles outlined above may be summarized as follows:

1. With the widely varying cost of different medical services at the present time, and the complex character of our population and its needs, the clientele of the dispensary should not be confined to the "poor," or to any single social group.

2. Who, then, should be dispensary patients? Those who need dispensary service and cannot secure equivalent medical service otherwise.

3. Remuneration of dispensary staffs must accompany extension of dispensary service above the low income levels of the population.

4. The regulations for admitting patients, the fees for treatment, and the compensation for those who do the work must be thoughtfully adapted to each of the particular groups in the community who need what the dispensary has to offer. An efficient administration of the dispensary according to these policies will confer benefit upon both the public and the medical profession.

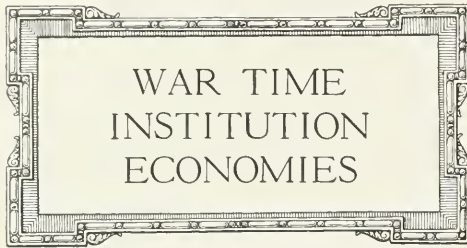
Special Courses for Teachers and Supervisors of Nurses Offered by New York Department of Nursing and Health

The New York Department of Nursing and Health, to meet the increased demand for teachers and supervisors of nurses, has arranged a special group of courses for the summer session. While the course is brief, it is believed that graduate nurses, who have a good educational foundation and have showed an aptitude for teaching, will derive considerable benefit from the work given. Those nurses who are particularly suited for teaching can give no greater contribution to their country now than by making themselves ready to teach and train others in the work of caring for the sick.

The department asks that superintendents of training schools cooperate to the extent of looking about among their graduates in order to find those who have had some previous teaching preparation or experience, and endeavoring to interest them in the courses offered for the summer session.

The total cost of the course, which extends from July 7 to August 16, is usually about \$120 to \$150. This includes living expenses.

Oklahoma state institutions are making special efforts to save flour, beef, pork, and sugar, and thirteen hospital, asylums, penitentiaries, and colleges report to the state federal food administrator monthly savings of 31,100 pounds of flour, 19,600 pounds of beef and pork, and 5,750 pounds of sugar.



THE CONSERVATION OF GAUZE*

A Measure of Patriotism as Well as of Economics—Process of Washing—No Special Machinery or Equipment Required

By NELL SHILT, R.N., Supervisor of Surgical Supplies, Lakeside Hospital, Cleveland.

One of the greatest questions that confronts the hospitals of today is the conservation of gauze. If we do not economize, we shall soon be called upon to use a substitute. Why not put that day off as long as possible by washing all gauze? This has been done for the past ten years at Lakeside and has proved entirely satisfactory. No special machinery or equipment is used, and no specific equipment. Every hospital has all that is required. No large amount of the used gauze is necessary to make the process pay. Any hospital will profit thereby.

In Lakeside all gauze whatsoever is washed and again put into use; gauze soaked with pus goes through the same process as gauze from clean wounds. All soiled gauze is placed in net bags hung in ordinary garbage cans by turning the top of the bag down over the top of the can. An effort is made to keep the gauze moist to prevent the setting of the blood pigments. These bags are collected in the afternoon. The string threaded through the top is drawn and tied and the bag transferred to the collecting can. The gauze is washed, sterilized, and returned to the supply room in this same bag. The soiled gauze is therefore not handled after being taken from the wound. The process of washing the gauze is the following:

The gauze, after being collected in the afternoon, is taken to the laundry and at the end of the day's work it is put in cold water and soaked for the night in one of the regular washers to prevent staining. In the morning it is rinsed through four or five cold waters with sufficient washing soda to make the water distinctly alkaline, then washed for twenty minutes through hot suds containing chloride of lime, and next through hot water with erusto salts or some substitute for oxalic acid for bleaching, then given another hot water and two water rinses. Next it is extracted and put through the autoclave for one hour at 20 pounds pressure, then returned to the supply room, and from here delivered to the public wards to be pulled or straightened out and sorted. It goes through the entire renovating process without being removed from the original bag in which it was collected. After pulling it is returned to the central supply room. Here it is sorted. The articles used in the operating rooms are returned to be prepared for sterilization by the operating room nurses. The tapes and articles used in operations can be put through the drying tumbler, which will take off most of the lint, or after being taken to the operating room can

be brushed with a stiff brush, so that they are absolutely free from lint.

In the supply room loose gauze is sorted for the various dressings, wrapped in double linen covers, and placed in the drier over night to become thoroughly dry. Perfectly dry gauze comes out of the sterilizing process much dryer than gauze even slightly damp. It is then put through the autoclave over 20 pounds' pressure for thirty minutes and 15 inches vac. for fifteen minutes. The fact that the washed gauze goes through the autoclave before it is handled at all has removed all objections to working with it on the wards or in the central supply room. Bacteriological tests have always proved it sterile.

In washing, the edges of the gauze fray and ravel badly. This means constant shrinkage and loss. To avoid this, as much gauze as possible is used in permanently made dressings. These are made in two sizes for hot dressings, a 10-foot narrow roll for neck and stump dressings, operating tapes, dressings, etc. Since we began using a large part of the gauze so made up into special articles, the work of pulling and sorting the gauze has been reduced one-half.

The new gauze is issued only through the central supply room and given out only when there is no suitable washed gauze to issue. Operating sponges are opened, and those in good condition reissued to the operating room. All new gauze is cut in the central supply room in sponges of standard sizes or in pieces of suitable size for the article desired. Whole bolts of gauze are not issued uncut. The sewing into made articles is done in the sewing room by machine.

The following table gives the amount of new gauze issued compared with the gauze actually prepared and sterilized in the central supply room. There is also given the ratio between these, which represents the average number of times the gauze is renovated and used:

	New gauze	Total gauze	Average number times used
1915	56,400	461,230	8
1916	53,700	491,076	9
1917	28,153	441,020	15

The 1918 figures will show a distinct saving over the 1917 figures.

* * *

CONSERVATION OF DRUGS AND OTHER SUPPLIES

Vancouver General Hospital Inaugurates an Economy Campaign—Economy Committee and Economy Officer Do Good Work

By M. T. MacEACHERN, M.D., Superintendent, Vancouver General Hospital, Vancouver, B. C.

"This is a time of economy and conservation." The Vancouver General Hospital used the foregoing as a basis for a conservation campaign two years ago. Since it is a large institution in which 78 percent of the patients in the public wards did not pay anything towards their maintenance, naturally a deficit was accruing. In addition, there was a constant increase in prices of all articles purchased.

The first step was the appointment of an "economy committee" whose duty it was to investigate every department of the institution with a view to checking waste and effecting economies, but maintaining or increasing efficiency. The committee carried on its work vigorously, and other members of the board, not on the committee, were privileged to attend any of the meetings. It thus served the further purpose of familiarizing them with the details of the various departments. Meetings were held twice a month and at each sitting took up one department or

*Read at the Fourth Annual Convention of the Ohio Hospital Association, Columbus, May 28-30, 1918.

another, with the head of that department present. Right here I might say that this procedure had a couple of advantages that we did not realize at first, namely, it increased the interest of the head of the department in his work and it gave the committee a chance to estimate just how efficient their employee was. After two years of persistent effort, we can truly say that there has been "economy with increased efficiency."

Six months ago we went one step further and appointed an "economy officer." It is one of his many duties to make a daily inspection of the institution for waste and to report it to the heads of the departments, who must take action. All garbage cans must be inspected before being emptied. A careful check on this, as well as many other things, has shown splendid improvement.

The introduction of the bedside selective service of food for all bedridden patients not only pleases the patient but saves a lot of food. From the food-carrier the patient is served at the bedside, and in so doing his or her tastes are consulted. Small quantities are served, but orders are repeated on request. The food service is quicker and far more satisfactory. During the first six months a conservative estimate was made and it was found that there was a saving of approximately 20 percent over previous systems and there were fewer complaints. The containers are taken back with the remaining food untouched and the plates usually come back clean. Special food-carriers were made locally for this work. The only complaint that we have received was a protest from the Chinaman who contracts for the garbage, inasmuch as his supply was somewhat reduced.

Recently we have taken up the question of conservation of drugs and labor in our pharmacy. This has been brought to a most successful issue and is producing genuine results now. Naturally, as we are an open hospital with a large number of doctors attending, there was a vast and varied number of drugs prescribed. To accomplish any change here it was necessary to have the cooperation of the medical men. A committee was, therefore, appointed from the medical staff to consult with the superintendent and pharmacist and to investigate the whole question and formulate a policy to produce the object mentioned. This committee did most commendable work. It was found that at present there is an ever-increasing difficulty in procuring certain drugs and a great advance in the prices of all drugs. Again, it was found that the work in the pharmacy of the hospital had of late tremendously increased and that trained pharmacists were practically impossible to obtain. The committee decided that greater economy should be practiced in the use of drugs and in the labor of handling them. To accomplish this the following scheme was worked out:

The pharmacist prepares a fortnightly drug bulletin, which contains a list of drugs most commonly used, with the present price, percentage increase over pre-war quotations, the amount available, and suggested substitutes which are more readily obtainable. This list is placed in a conspicuous place in the hospital and a copy mailed to each doctor's office. It was felt that the knowledge thus disseminated would be valuable to the physicians in conserving, in private as well as hospital practice, those drugs the quantities of which are low and the prices high.

It was also recommended that, if prescriptions are to be repeated, a written order should be required from the doctor, who would be notified the day before the medicine was finished. In addition, the prescribing of drugs by the dosage, with an indication of how many doses are to be sent to the ward at a time, has also been very advan-

tageous. Not only does it conserve the amount of drugs used, but it is instructive to nurses and others inasmuch as they get more familiar with dosages. Thus when a patient was being discharged from the hospital within a day or so after the completion of the medicine or mixture, only sufficient would be ordered for the duration of his or her stay as a patient in the hospital.

It was found that certain prescriptions could be cut down in the number of ingredients used, inasmuch as, in some cases, an individual drug would answer the purpose as well as two or three possibly prescribed.

Again, the various forms of administering drugs requires greater or less time in preparation. For example, emulsions take longer than capsules or powders and the latter longer than mixtures, and thus the simpler form of administration, employed wherever possible, would conserve a good deal on the labor.

Some time ago the hospital issued a very complete pharmacopeia, and this is kept in each ward in a conspicuous place. Every prescription or order blank which the doctor uses in the ward has printed in the center of it "use hospital pharmacopeia," and thus acts as a constant reminder. The use of the pharmacopeia means that more stock solutions can be used and more uniform methods of prescribing adopted.

It was found also that doctors, inadvertently, are not explicit enough in prescribing, and sometimes even call for incompatible drugs in their prescriptions. The dispenser, therefore, loses time in getting in touch with such men for revision of prescriptions. Greater care, therefore, in future will be employed in the writing of such prescriptions. Again, in the prescribing of unstable solutions, it must be remembered that only a sufficient quantity for the period of stability should be ordered.

The excellent work done by this committee was heartily endorsed by the medical association and put into effect immediately. So far the results have been satisfactory, and in the first month the chief pharmacist reports a saving almost sufficient to take care of the payroll for that month.

There have been many other features in our "economy and conservation" campaign, but space does not permit a more detailed report. From our work I have deduced the following conclusions:

1. Every hospital should economize and conserve on materials and everything used, as well as on labor.
2. With economy and conservation there should always be maintained an increased efficiency.
3. To economize and conserve you must have the cooperation of the heads of all departments and people interested.
4. You must have organization and system to carry such work to a successful issue, and always have careful and constant checking.

Are your pupil nurses happy in their home? If they are not, they will not recommend the school to their friends, and, after all, pupils and graduates are the liveliest possible advertising agents for the school. It oftentimes happens that some little, inexpensive thing can change the whole atmosphere of the home. The matron of the home can tell you what the girls want—they are really girls when they are in their home, whatever may be their relation as "women" in the business life of the hospital.

The making and the executing of a good resolution are two entirely different actions.—W. J. Locke.

THE WAR: ITS HOSPITAL, MEDICAL AND NURSING ASPECTS

AMERICAN WOMEN'S HOSPITALS

Plan of Organization—Work of Doctors, Technicians, and Lay Workers in France, Serbia, and Palestine—American Red Cross Gives Permission for Establishment of Hospitals in the War Zone

BY CHARLOTTE M. CONGER, Executive Secretary, American Women's Hospitals, New York.

The American Women's Hospitals is about to celebrate its first anniversary. It was organized in June, 1917, by the War Service Committee of the Medical Women's National Association, appointed by the association at its first meeting after war was declared.¹ The unwieldy name "War Service Committee of the Medical Women's National Association" was soon changed for the shorter and more easily handled one "American Women's Hospitals," and, through the courtesy of a public-spirited New York citizen, Leo Schlesinger, was established in a suite of three large rooms at 637 Madison Avenue, at the corner of Fifty-ninth Street.

The American Women's Hospitals made haste slowly; in other words, they dug deep for the foundation of their structure and built it solidly. A broad plan of work was formed, which included every medical need created by the demands of the war and the call of medical men for military service. Affiliation with the government was naturally the first appeal and a committee was immediately sent to interview the military departments of the government and the national Red Cross in regard to the association of the American Women's Hospitals with these bodies. They were told by those in authority, both in the War Department and the Red Cross, that every medical woman in the country would eventually be needed for war service, but at the War and Navy Departments this committee was informed that women were not needed as yet in the Medical Reserve Corps of these military branches and no provision had been made for their appointment to them, although the Surgeon-General of the Army warmly approved the plan submitted. The Red Cross, on the contrary, having already tried out women physicians and found them acceptable were only too glad to avail themselves of the cooperation offered by the American Women's Hospitals.

The original plan of this organization, a plan which inspired the adoption of its name, was, following the example of the Scottish and British medical women, to form a chain of hospitals in the war zone. This project did not at this moment meet with the favor of the Red

Cross through which all such work must be done. They were, however, willing to send medical women as individuals to work in the devastated countries abroad, and sixty-two members of the American Women's Hospitals, forty-eight doctors, and fourteen technicians and lay workers are scattered throughout the devastated area of France, on the Serbian border, and in Palestine. Dr. Lucas, in charge of the medical department of the Red Cross in France, now on leave of absence in this country, tells thrilling and interesting stories of the work of these devoted women.

At Toul, until lately, was Dr. Alice Barlow Brown of Winetka, Ill., and Dr. Marion Stevens, a dentist of Springfield, Mass. Dr. Brown's special work, the care of six or seven traveling dispensaries, made such a drain upon her that a few weeks ago she broke down and was compelled to retire to rest and recuperate. Her place has been taken by Dr. Esther E. Parker of Ithaca, N. Y. The hospital at Toul contains two hundred beds, fifty for pregnant women, the remainder for children. Since it was



Fig. 1. M. Leibert, Consul General of France, Dr. Rosalie Slaughter Morton, chairman of the executive board of the American Women's Hospitals, and a group of doctors ready to sail for the other side. In the foreground are two Red Cross nurses.

started, less than a year ago, between five and six thousand mothers and children have been cared for by the doctors in charge.

At Evian there is a hospital for the *répatriés*. Thirteen to fifteen thousand a day are returning from the invaded regions. 15 percent of whom are children. In charge of the contagious hospital at this point are two little Quaker doctors, sisters, who were in the first group sent out by the American Women's Hospitals—Drs. Dorothy and Florence Child. They write of their work there as follows:

"We arrived safely in Paris, and were detailed to go at once to this hospital at Evian. We found a fine hospital building (adapted from a hotel) and a staff including 10 nurses, a dietitian, administrator, housekeeper, etc. At that time the hospital was ten days old and had 20 patients. It is now four months old and has 180 patients, 20 nurses and 20 aids. The children we treat are refugees. They have been prisoners of war in occupied France and in Belgium for three years or more. They have experienced all the horrors of war; they have lived in the din of cannon and shells in cellars and huts. They have lots of skin diseases from the dirt, and they are poorly nourished, and nervous and fidgety because of the noise and strain.

"The hospital has gradually developed into an isolation

¹Of this committee Dr. Rosalie Slaughter Morton was made chairman. Associated with her as an executive committee were Drs. Emily Dunning Barringer, vice-chairman; Mary Merritt Crawford, corresponding secretary; Frances Cohen, recording secretary; Belle Thomas, associate secretary; Sue Radcliff, treasurer. This committee has since been increased and to the above names the following have been added: Drs. Mathilda K. Wallin, second vice-chairman; Caroline M. Purnell, third vice-chairman; Marie L. Chard, assistant treasurer; Gertrude A. Walker, chairman of finance committee; Mrs. Conger, executive secretary; Miss Bertha Rembaugh, counselor.

system for the contagious. Every children's disease is represented. During the winter, we had many pneumonias, too. We have often had as many as three bad laryngeal diphtherias at the same time. In addition to the hospital, we have a dispensary fitted up in the garage for medical, surgical, and dental work. Another building is a temporary orphanage. Here orphans spend two weeks to see if anything contagious will develop, and to be vaccinated and antitoxined, before being distributed to orphanages in the interior of France. In another building a day school is run for the refugee children that stay in Evian for a few days for any reason. Since they arrive at the rate of 1800 to 2000 persons a day, you can understand that they must be cleared out very promptly, to make room for more."

Another member of the American Women's Hospitals, Dr. Virginia Murray of California, is in charge of the convalescent home at Lyons, a hospital containing two hundred beds which receives the children sent on from Evian.

In the chateau region of the Blois is Dr. Bertha Stuart, of Portland, Ore., who is developing a hospital, convalescent home, and dispensary; of her work too much can

Dr. Keyes writes from Vodena, Salonica, "This hospital building was formerly a Turkish school, and we are having it all painted inside and whitewashed outside and all done over. We are building new sanitary toilets and putting in a shower bath, not as we have in America, but crude, still they help out."

In Serbia the American Women's Hospitals will establish a hospital of 250 beds. Through the generosity of Mrs. Frederick Thompson, a motor laboratory has been built and equipped which will shortly be sent to Colonel Petkovitch in Serbia.

After a year's study of the situation on the other side, the American Red Cross no longer holds out against the establishment of hospitals. They have already given permission to the American Women's Hospitals for the placing of two small hospitals in the department of the Aisne. One of these is about to start and will be equipped, staffed, and financed by the American Women's Hospitals. Its director is Dr. Barbara Hunt of Bangor, Maine. Dr. Hunt



Fig. 2. A motor laboratory built and equipped by the American Women's Hospitals.

hardly be said. No camionette being at her disposal, she for a while walked ten miles hither and thither carrying aid to those who could not come to her.

Dr. Ida Shields is at St. Etienne, the Pittsburgh of France, where the demands are such that the doctors in charge are working sixteen hours a day. Just now they are establishing a hospital there of seventy beds, and layettes have been in great demand. Dr. Shields writes, "I don't expect you can find a place in France where there is greater need than there is in St. Etienne. There are 150,000 refugees here living under the worst city conditions."

The hospital for Serbian refugees at Vodena, Greece, which is a converted school house, rudely equipped and with crude but effective plumbing, is presided over by Dr. Regina Flood Keyes of Buffalo, N. Y., with Dr. Mabel Flood as her assistant. Dr. Keyes and Dr. Flood visit three thousand refugee families daily, take care of sixty to seventy dispensary patients and look after fifty bed patients. With them it is in truth "all work and no play" and they are handicapped in their work by lack of rank, which both the Scottish and British women working near them have.



Fig. 3. An interior view of the motor laboratory which the American Women's Hospitals will send for service in Serbia.

will have associated with her, a lay woman, Mrs. Lida Touzalin of New York and Colorado Springs; her assistant will be Dr. Ethel B. Fraser of Denver. Another member of Dr. Hunt's staff is Dr. Mary Getty of Philadelphia, who goes as ophthalmologist and for general medicine.

Dr. Doherty of Milwaukee is the dentist of the group just starting. There will be three graduate nurses connected with this hospital: Miss Merrick of New York and Miss Whitaker and Miss Pettengill of Pennsylvania. Miss Ada Tobbutt as recorder and Mrs. Lida Braschi and Mrs. Lehman Lenoir, ambulance drivers and mechanics, complete the group.

Despite the demands of the war and the number of physicians sent to the front, the Medical Reserve Corps of the United States Army still remains closed to women physicians, our country refusing to follow the example set by the English, who have placed women in charge of their military hospitals, notably the one in Endell Street, London, of six hundred beds, which is directed by Dr. Garrett Anderson. But women have been appointed as contract

surgeons in the army where they are on the same basis as men; also—and this is a new departure—five women bacteriologists, members of the American Women's Hospitals who took the special course arranged by this organization, have been appointed as students in the Army Medical School in Washington, which are important steps toward federal recognition.

The American Women's Hospitals receive frequent requests from industrial centers for women physicians to examine and care for the factory worker and to fill the vacancies made by the enlistment of medical men in the federal service. Also the hospitals throughout the country are opening their doors to women and appointing them to positions hitherto filled by men. This is true of nearly all the hospitals in New York. The American Women's Hospitals have cooperated with the Women's Committee of the Medical Board of the National Council of Defense wherever their work touched and to them and all those seeking information, their card index and cross files are open. They are affiliated with the American Committee for Devasted France, the Fund for French Wounded, the National Surgical Dressing Committee, and various other patriotic societies.

The index and cross files have been an important feature of their work. As soon as the organization was complete an outline of the plans American Women's Hospitals and registration were mailed to five thousand medical women in the States with the result that some fifteen thousand registered with the American Women's Hospitals for foreign or home service. From these files the doctors sent abroad for the Red Cross and those furnished for the industrial plants and hospitals throughout the country have been selected.

The registration completed, committees were formed with medical women of national reputation at their head for foreign service, for the establishment of army hospitals in the home zone, for the care of prisoners of war and interned alien enemies, for sanitary inspection of camps, for laboratory work in connection with civil and military hospitals, for hospital substitution, for substitution in private practice, for dental service, and for supplying physicians for industrial plants. These committees have all been active since their creation, save that of the care of prisoners of war and interned alien enemies for which service no one has so far been called.

NEW FIELD AND HOSPITAL USE FOR THE ARMY LITTER*

Universal Instrument for Loading, Transporting, and Treating Wounded Soldiers

The present war has developed many novel and ingenious contrivances for the care of the sick and wounded soldiers and new methods of using equipment already at hand. Maj. H. B. Allen, M. R. C., director of the Camp Greenleaf School of Applied Surgical Mechanics, has devised a simple but effective method of loading, immobilizing, and transporting wounded soldiers. His plan does not call for new or elaborate apparatus, but utilizes the regulation hand litter now in use by the medical department of our army.

The ideal "stretcher" is necessarily the one which facili-

tates the loading and transportation of wounded soldiers without additional trauma, with the minimum amount of labor, and with the greatest rapidity. Major Allen's method of using the standard litter as a splint meets all these requirements, and, in addition, actually places the patient under treatment the moment he is loaded and immobilized on the litter. The following description and the accompanying illustrations clearly demonstrate the value of the Allen method:



Fig. 1. Patient and litter turned on the left side. The foot of the injured side, the left, has been tied with the left front litter sling and the right rear sling has been passed in front of the right shoulder, down back of the pelvis and forward through the crotch tilting the pelvis by traction on rear sling.

of the
blanks
United

"Among the numerous innovations at Camp Greenleaf there is one that will contribute both comfort and surgical aid to each of the million and more wounded soldiers every



Fig. 2. The litter loaded.

year, whose wounds are so serious that they must be transported upon a litter. This innovation costs nothing, since it neither adds to nor subtracts from the army litter as it stands today and has stood for many years. Loading the stretcher requires but one man. It is literally a one-man job, and he can crawl out on his belly to his patient and load him on the litter, exposing himself to the minimum of fire. It is obviously true that, ordinarily, two men are necessary to carry the loaded litter. It may be transported back at any opportune time, but it must be remembered that the patient is comfortably immobilized and is actually under treatment although left alone out on the field. The soldier is loaded on the stretcher by first tying the foot on the injured side to the front end of the litter with the litter sling. The sling from the rear end of the litter is passed over the shoulder down behind the soldier's back and is brought up between his thighs. Then the soldier's belt is used to elongate the rear sling by passing it through the handle loop and buckling it around the rear handle of the litter. It is buckled just tight enough to make the pelvis tilt up on the sling side, as far as its anatomical range will permit. The patient and the litter together are

*The illustrations to this article are presented by courtesy of the Military Surgeon.



Fig. 3. The rear sling, elongated by the patient's waist belt, is passed through loop of sling and buckled around the rear handle of the litter on uninjured side efficiently immobilizing the patient and permitting the tilting of the litter to either side.

gently turned until the loaded litter rests on its feet right side up, and the patient upon it, comfortably immobilized, is actually under treatment, so far as injuries to the legs or thighs are concerned.

"Immobilization by the use of fixation forces for fixation purposes is the platform upon which all successful fracture work rests. It should be noted that the patient is loaded without being unduly handled or carried to the litter, and no splints are required, no grass, or weeds, or sticks are used, nor is one crooked leg tied to another crooked leg as a substitute for a splint. There are many splinted patients in hospitals today who would do infinitely better if treated on an



Fig. 5. One stretcher bearer carrying loaded litter on his back. Patient completely immobilized.



Fig. 4. Litter approaching vertical, feet of patient up.

army stretcher, made up like a bed, with an 8-inch hole cut through the canvas for daily bed-pan service. This 8-inch hole for bed-pan service eliminates the excruciating pain endured by the patient every time he is lifted on the bed pan. By this method the patient and the litter are one and his injuries are not disturbed in any way by lifting on the litter to put the bed pan in place and remove it.

Fractures or shell wounds of the arm, forearms, legs, thighs, trunk, neck, or head are immobilized and transported by the employment of suitable fixation forces for fixation purposes. Pads under the point of attachment and possible pressure are readily applied as indicated.

"Pain from fractures is chiefly due to the prodding of soft, sensitive tissues by sharp jagged bone fragments; but if the bones are pulled down to their normal positions and fixed there by fixation forces, then there can be no

prodding. By this means the chief element in the production of pain is instantly eliminated. In this connection there is another feature that is even more important than the elimination of pain and that is the elimination of the possibility of additional damage due to the prodding ends of the bones grinding against each other, or lacerating the soft tissues. Lacerated tissues (hard or soft) are known to be excellent incubators for serious infections.

"That these fixation forces produce effective immobilization may be inferred from the accompanying illustrations, and proved by asking a patient so treated. But if one really wants to know what a strait jacket actually feels like, then have some one immobilize him on a litter by

the Allen method. I have tried it myself and have observed two very interesting results. First, immobilization is certainly present in very large quantities, and second, the complete absence from pain or discomfort is surprising. The reason for the absence of pain is the absence of traction. Traction is not constant; it is only present when the litter is markedly tilted or when the muscles contract, but since the muscle contractions are blocked by adequate fixation forces, they are deprived of their normal attribute of producing motion. The explanation is simple enough when you stop to think about it.

"The patient can be carried with either end of the litter raised, making it possible to remove



Fig. 6. Complete immobilization, all extremities broken.

wounded soldiers out of deep dugouts, or transport them around the sharp, narrow angles of the trenches.

port them around the sharp, narrow angles of the trenches.

"All of this can be done without altering the army litter,



Fig. 7. Immobilization maintained even when the litter is carried by the handles of either side.

but if a soldier has both arms and legs fractured, or is badly torn by shell fragments, or crazed by poison gases or other causes, then additional dressings and retention straps would be required. With little expense these padded straps and sole cleats, and the 8-inch hole in the canvas, can be supplied making the U. S. litter a universal instrument for loading, transporting and treating wounded soldiers.



Fig. 8. Two men immobilized on the same litter.

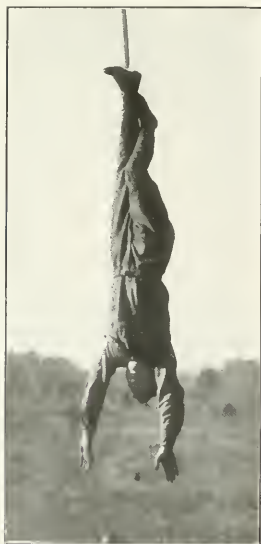


Fig. 9. Demonstrating the efficiency of the Allen shoe cleat, as well as the army shoe and belt.

"As an apparatus for hospital treatment it is only fair to say that its hospital record is in no sense inferior to its qualities as a means of transportation. The limited allotment of space prevents narrating the great variety of cases more appropriate to litter treatment than to any other

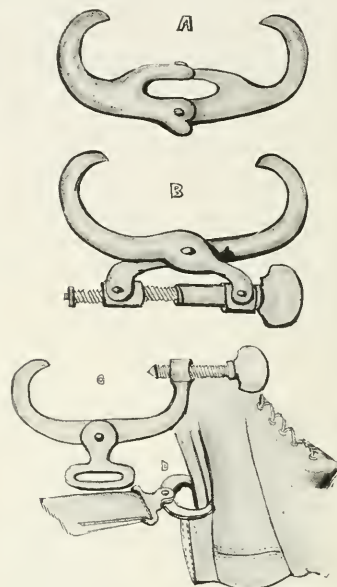


Fig. 10. Different types of Allen's shoe cleats.

single device. The many appliances now in use can be employed better with the stretcher than without it but that opens up another chapter much more elaborate than that already presented."

"It has been suggested that nurses in military service shall be given commissions entitling them to rank similar to that accorded to medical officers.—News Item.

"Oh, Captain Nurse," the surgeon said,—

A first lieutenant pale and wan,—
He stood there on the battle field

As black of night was paled at dawn,

"Oh, Captain Nurse," the surgeon said,

"How goes the work along this route?"

"My dear Lieutenant," nurse replied,

"I first must ask you to salute."

He raised his hand to helmet brim

And she saluted back at him.

And then replied good Captain Nurse,

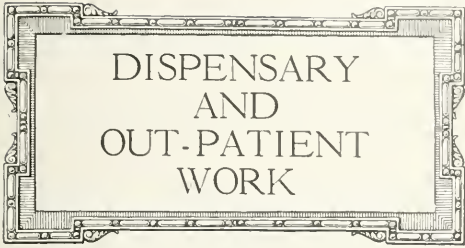
"I think that I've seen matters worse;

But, dear Lieutenant, don't forget

Your military etiquette."

—Illinois Health News.

Your manners will depend very much on the quality of what you frequently think on, for the soul is as it were tinged with the color and complexion of thought.—Meditations of Marcus Aurelius.



Conducted by MICHAEL M. DAVIS, Jr.,
Director of the Boston Dispensary.

Please address items of news and inquiries regarding Dispensary and Out-Patient Work to the editor of this department, 25 Bennett street, Boston, Mass.

MASSACHUSETTS FINDS EFFECTIVE REMEDY FOR DISREPUTABLE DISPENSARIES

New Law Regulating Massachusetts Dispensaries—Dispensaries to be Licensed by State Board of Health

The war and its demands for physical fitness have drawn public attention, as never before, to the menace of disease and the agencies for preventing and curing it. In Boston, this focusing of public attention brought to light several disreputable dispensaries, organized purely for gain and exploiting their patients and the community. This led to a campaign by the Boston Chamber of Commerce, through its bureau of investigation, of which Mr. E. B. Hayes is executive secretary, which resulted in having the charter of one dispensary annulled and the doors of another closed.

At this juncture Mr. Michael M. Davis, Jr., director of the Boston Dispensary, addressed a letter to the Boston Chamber of Commerce, in which he pointed out that the one effective remedy for the situation lay in statutory state regulation. This led to a conference of representatives from the State Department of Health, the State Board of Charities, and the Boston Chamber of Commerce, to consider the draft of an act drawn up by Mr. Davis, providing for the licensing, inspecting, and regulating of all dispensaries throughout the state of Massachusetts. The bill became a law on April 2, 1918.

The law defines a dispensary as "any place or establishment, not conducted for profit, where medical or surgical advice and treatment, medicine, and medical apparatus, is furnished to persons non-resident therein; or any place or establishment, whether conducted for charitable purposes or for profit, advertised, conducted or maintained under the name 'dispensary,' or 'clinic,' or other designation of like import." The law makes it unlawful for any person or association other than the regularly constituted authorities of the United States or of the Commonwealth, to establish or conduct any dispensary within the Commonwealth without first obtaining a license.

Any person or association desiring to conduct a dispensary must apply in writing for a license to the State Department of Health. Attached to the application must be a statement containing such information as may be required by the department of health. If, in the judgment of the department, the statement filed and other evidence submitted in relation to the application indicates that the operations of the proposed dispensary will be for the public benefit, the license is issued to the applicant. Licenses expire at the end of the calendar year in which they are issued, but may be renewed annually on applica-

tion. No license is transferable except with the approval of the department of health. For the issue or renewal of each license a fee of \$5 is to be charged, except for incorporated charitable organizations which conduct dispensaries without charge, and which report, as required by law, to the State Board of Charities.

The law provides that the public health council of the Department of Health shall make rules and regulations in accordance with which dispensaries shall be licensed and conducted, but no such rule or regulation shall specify any particular school of medicine in accordance with which the dispensary shall be conducted.

The commissioner of health and his authorized agent have authority, under this law, to visit and inspect any dispensary at any time in order to ascertain whether it is licensed and conducted in compliance with the law and with the rules and regulations under which it is established. The State Department of Health may, in its judgment the public interest so demands, revoke the license of any dispensary after thirty days' notice and opportunity to be heard.

Dispensaries legally incorporated or in operation in the state, at the time of the passage of the act, are allowed upon application to continue in operation for the remainder of the calendar year, without fee. The State Department of Health, however, is directed to have an inspection made of all dispensaries in the state by December 31, 1918. Any person or association conducting a dispensary without license, or wilfully violating any rule or regulation made under the authority of this act, is guilty of a misdemeanor, and if convicted must pay a fine of not less than \$10 or more than \$100. A separate and distinct offense is deemed to have been committed on every day during which the violation of any provision of this act continues, after due notice of the violation is given in writing by the department of health to the authorities of the dispensary concerned. The commissioner of health is made responsible for reporting any violation of the act to the attorney general.

New York and Boston Call for Volunteers for Dispensary Service

With the progress of the war and the growing withdrawal of physicians from civil life into military service, the dispensaries throughout New York City, like dispensaries elsewhere, are finding it increasingly harder to man their clinics adequately. In some instances, where all the physicians of given clinics have entered the army service, the dispensaries have actually been forced to close them for the period of the war; in other instances the services have been curtailed, often seriously; and in not a few instances the men who remain are carrying an almost unbearable burden of work and responsibility. In an effort to relieve this situation somewhat and to enable the dispensaries to meet the increasing demands that are bound to be made upon them as the war goes on, and the lack of physicians makes dispensary treatment imperative, the Associated Out-patient Clinics of New York have called upon the New York, King's and Bronx County Medical Societies to bring this situation to the attention of physicians at large and to urge as many as possible to volunteer their services for the duration of the war. It is to be hoped that many who have had dispensary experience, but who at present have no hospital or dispensary affiliation and who, because of age or for other reasons, are not available for medical service, will volunteer for dispensary duties as their contribution to the war.

INDUSTRIAL REHABILITATION OF DISABLED SOLDIERS AND SAILORS

Conducted by ELIZABETH G. UPHAM,
Director Art Department Milwaukee-Downer College.

AGRICULTURE FOR THE DISABLED*

Experience of Various European Countries and Canada— Therapeutic Value of Agriculture

In every country, the men left the plow, the orchard, and the dairy to join the colors. Every country is meeting the necessity of returning her men to the land, many of them severely handicapped. To what extent agricultural pursuits are suitable to the disabilities of war invalids, has been a matter of serious concern.

Agriculture at first glance seems especially unsuited to the disabled. Adequate remuneration for the hard work



Fig. 1. Poultry farming for blinded soldiers and sailors in Kent.

expended is difficult, at best, for the average farmer. Agriculture, however, is becoming more and more specialized, and scientific instruction is not only decreasing labor but increasing yields. Moreover, the motor tractor and modern machinery are performing an ever-increasing part of the heavy farm labor. Farmers' institutes, rural organizations, good roads, and automobiles are overcoming the isolation of the farmer. Moreover, serious study made of agricultural occupations in relation to disabilities, shows

that these occupations are of therapeutic value in many conditions. Patients with arrested cases of tuberculosis, neurasthenia, shell-shock, and gassing improve perceptibly by employment in the open. Prosthetic appliances have a variety of grasps and devices designed to enable the men who have suffered amputations to perform farm work. In the shortage of farm labor, therefore, it has become the economic policy of every nation to return to the land those who are capable of production.



Fig. 2. A soldier with right arm amputated who has been fitted with an appliance which permits him to use the scythe, etc.

France made the early blunder of permitting 90 percent of her disabled from rural districts to train for clerical positions. The tendency had been for the agricultural workers of France to go to the front and for those engaged in industries in cities to remain as munition workers. Therefore, industrial occupations, especially the apparently easy clerical positions, looked attractive to the returned soldier and seemed to offer less liability for him and his sons to take part in future wars. France had to institute an active propaganda for the return of her men to the land in order to offset this early blunder. The men are frequently loath to undertake agriculture with its isolation and heavy work. As one Canadian soldier expressed it, "I have had all the land I ever want, slept on it, ate it, and had it on my clothes." Another soldier said that he didn't want any more fresh air, he preferred a warm shelter and the close atmosphere of the movies.

The nations have found it necessary to make special inducements in their propaganda to return the men to the land. Germany has a scheme whereby she grants small rural homesteads to war invalids and further assists them by loans. In Italy the men's pensions are accepted as security by all public administrative bodies for loans for buying lands.

*The illustrations accompanying this article have been supplied by courtesy of the Red Cross Institute for Crippled and Disabled Men, New York City.

In France it is proposed to have an occupational map on which will be represented all the products of French soil. With this map will go a stirring appeal to the agriculturalists to show them the trades and occupations which handicapped men can undertake upon the land. France is primarily an agricultural country, and the terrible wastage of her fields, the destruction of her orchards, vineyards, roads, and rural communities can only be restored by training her returned men in new methods of intensive farming.

Great Britain is making extensive plans for colonization. Canada is studying crown-land legislation which is in advance of even Australian schemes. The land settlement

breeding, dairying, farm mechanics, soil analysis, fertilization, and farm economics and management. The first prize at the Edmonton Horticultural Society Show was won by a member of the Canadian Vocational Training Class, for vegetables grown in competition with professional growers of Alberta.

The providing of agricultural instruction and the propaganda to return the men to the land has thus far been conceived chiefly as a national economic policy by the government in order to increase farm production, develop new resources, and removed the disabled from congested cities. The return to the land, however, has a special significance to doctors and to those engaged in rehabilitation, for the land and agricultural processes offer real therapeutic possibilities when properly understood.

While the patients are convalescing their agricultural training is begun. The exercise, out-of-door life, and healthy interest benefit the patient as well as hasten his recovery. Several French surgeons testify to the superiority of exercise on the land over the induced exercise of mechanotherapeutics. Dr. Bergonié compares the results in after-care of the wounded at Temporary Hospital No. 4, Grand Lebrun, Bordeaux, which is a physiotherapy center, with the work at Martillac where the men follow prescribed exercises in the fields. He says: "We were able



Fig. 3. Soldier with double forearm amputation working with a spade. Right arm with single hook, left arm with ring hook "Aubut."

plan of Ontario is particularly interesting. The Soldier Settlement Act provides that Dominion lands on each side of a railway shall be reserved for a depth of fifteen miles for returned soldiers. The government proposes to give each settler an eighty-acre lot, including a ten-acre clearing, and a loan not to exceed \$500 for the purchase of tools and live stock. Roads will be built, a community life provided, and the men given agricultural training and supervision. In each center there will be houses, heavy farm implements, and machinery which will enable the men to have the use of the best agricultural equipment on easy terms.

The men are placed in communities where they may have some social life and where they will be supervised. They are carefully directed into that branch of agriculture which will not only be beneficial for them, but at which they may hope to secure a fair living. They are, moreover, given the opportunity of special instruction in an agricultural school for the disabled. The men apply themselves with concentration and enthusiasm. There are classes in truck gardening, bee and poultry-raising, stock-



Fig. 4. French soldier fitted with a prosthetic appliance which enables him to use the spade and other agricultural implements.

to prove how far the agricultural remedy was superior in percentage of cures as well as in rapidity and thoroughness to mechanotherapy, and even to all physiotherapy, carried on indoors at the Grand Lebrun Hospital."

Accidents and changes for the worse do not exist: 80 percent of the men, after agricultural treatment, are cured and able to return to the service, only 10 percent showing

an improvement insufficient to permit them to return, and 3 to 5 percent remaining in an unchanged condition.

Collective work under supervision yields better results than individual work.

There is one danger in the work. The enthusiasm which the men feel when they find themselves once more in their fields, and when they find that they are again capable of productive labor is so great that they may overdo and retard their recovery. For this reason, it is necessary not only to assign each man the task compatible with his disability but to limit his effort.

Thus work is made progressive and is interrupted by frequent periods of rest. The open air and sunshine are not without their benefit also. Faces that are pale in the hospital rooms of mechanotherapeutics, regain their color and tan in the open.

There must be the most careful selection of cripples. The nature of the work and the functional condition of the cripple must serve as guides. For instance, occupation could not improve such conditions as ankylosis, a limitation of motion due to an osseous obstacle, or paretic disorder caused by injury to the nerve, whereas an articular stiffness, caused by contraction or prolonged immobility or functional disuse, is benefited by occupation.

The success of agriculture as a therapeutic agent lies, first, in the careful choice of patients, second, in adapting the occupation to the functional disorder, and, third, in the constant supervision of the patient in order to see that he is deriving benefit rather than harm from his work and that he is well housed and fed and his resistance to fatigue increased. The work thus supervised constitutes a real cure.

The regents of the University of Michigan at Ann Arbor have had plans drawn for the erection of a \$35,000 building for children at the University Homeopathic Hospital. The new building will be a two-story structure with basement and attic, and will be located thirty feet east of the main unit of the hospital, with which it will be connected by an underground passage. The exterior, like that of the main building, will be of pressed brick with a tile roof. Although, owing to the present high cost of materials, the structure will not be entirely finished by next summer, the first and second floors will be ready for patients at that time. Each floor will contain a public ward with 50 beds each and three private wards, besides executive offices, examining rooms, and treatment rooms. When the remainder of the building is eventually completed, the basement will quarter the x-ray department, and the attic will serve as a storeroom.

The Lake County Council for Defense at Crown Point, Ind., have drawn up a resolution to be presented for adoption by the Board of County Commissioners providing for the establishment of a county tuberculosis hospital, at an initial expense of approximately \$100,000. It is expected that the commissioners will authorize a bond issue to be presented to the bond attorneys in Indianapolis for their approval, and in the event that they decide that there is any doubt as to the legality of the action taken by the county commissioners without submitting the proposition to a vote of the people of Lake County, a friendly suit will take place in order to settle the point. The action taken by the County Council for Defense was instigated by the refusal of their chairman to accept the opinion of Attorney General Stanbury and Judge O. L. Wildermuth of Gary, that the commissioners can establish the hospital without submitting the question to the voters.

AN AMERICAN SCHOOL OF REEDUCATION FOR CRIPPLED MEN

The Work of the Red Cross Institute for Crippled and Disabled Men of New York City—The Methods of a Special Employment Bureau for the Handicapped

By DOUGLAS C. McMURTRIE, New York, Director of the Red Cross Institute for Crippled and Disabled Men, President of the Federation of Associations for Cripples, Editor of the American Journal of Care for Cripples.

[Continued from June issue.]

DEPARTMENT OF FIELD WORK

An important feature in the work of a reeducational school is getting in touch with prospective pupils at the earliest possible date. Actual case work in the field not only effects acquaintance with suitable subjects for training, but also, by bringing to light the economic experiences of cripples who have succeeded in overcoming their handicaps, is extremely suggestive regarding possible trades, employment opportunities, and the methods to be followed in dealing with other cripples similarly disabled.

The first field activity of the institute consisted in a study of case histories of disabled men whose injuries had occurred since January 1, 1915. Trace of such cases was obtained through the hospitals of the city, through the Industrial Commission, through a public service corporation, and through other sources. The cases thus listed numbered in total 743. From those men who could be found, 361 complete case records were obtained.

The findings of the study, as prepared by Dr. J. C. Faries, have been published in detail, and will be found of much scientific interest. Another consequence of the study was that it put the institute in communication with many men who could profit by instruction in its training classes.

The principal field activity at present is persistent visiting of the city hospitals by a social worker experienced in dealing with cripples. This worker gets in touch with maimed men immediately after the amputation has been performed, gains their friendship and confidence, stimulates their courage, and plans with them their future program of training or employment. Under these circumstances, a disabled man can leave the hospital with a very definite prospect in view.

Another activity of this department is the conduct of a series of "parties" for cripples, the object of which is to hearten and encourage the handicapped men who are losing out by bringing them in touch with the cripples who have overcome their obstacles. The first gathering of this sort was nothing short of inspiring. Over two hundred cripples were invited, and over seventy-five came, although the evening was one of the coldest of the winter. The director of the institute opened the meeting with a description, in simple language, of what was being accomplished by war cripples abroad, and illustrated with a generous number of lantern slides and one moving picture. Next were shown two motion pictures showing two successful cripples at work and play. In conclusion, two cripples themselves told the audience of their experiences in getting the best of their handicaps. One of them had amputations of both arms, yet runs one of the busiest news stands in New York; the second lacked one arm and one leg, but has risen to be purchasing agent of a large western corporation. Then came ice cream and cake. Most of the men lingered long to swap experiences.

The influence of the meeting was reflected immediately in an increase of applications to the employment bureau for work and to the educational department for admis-

sion to the industrial classes. The experiment was a vivid demonstration that no one can encourage a cripple so effectively as another cripple.

The second meeting was similar in general plan, and if possible, even more inspiring. It was addressed by two men, one of whom has lost both arms, the other lacking one arm and both legs. There were shown for the first time three moving pictures, planned and photographed by Capt. Arthur Samuels of the surgeon general's office. Each illustrated how the seriously handicapped cripples overcome their obstacles.

Between pictures there were short talks to the crippled audience by crippled speakers. The first address was by a man whose extremities had been frozen by exposure in a blizzard, and consequent amputation of two legs, one arm and four fingers of the remaining hand. He had then become for two years an inmate of the poorhouse. He told the county authorities that if they would give him just one year in college, he would never again cost them a cent, persuaded them to do so, and made good his predic-

tion and manufactured his own appliances, with the aid of which he does practically every duty of daily routine, including putting on his collar and tie, engaging in a game of bowling, or pruning his own peach trees. He was elected by his county to be justice of the peace, and later was thrice chosen for the responsible task of county judge, which office he now holds.

The "cripple parties" are an assured success and will be continued as a permanent institution.

EMPLOYMENT DEPARTMENT

Historically, the placement of crippled and disabled men has been found one of the most difficult specialties in social work. It has been attempted at various times and places, but in few instances have the efforts been successful.

One of the successful efforts was a small employment bureau for cripples, which was established by the Federation of Associations for Cripples in cooperation with Hudson Guild. At the time the institute was established, this bureau had been in operation a little over a year. As its work, however, led directly along the line of the re-educational program, and as the bureau was handicapped by lack of facilities, it was taken over by the institute. This early experience proved a splendid foundation on which to base the more extensive activities now under operation.

The employment department is not a general bureau for the handicapped, but registers orthopedic cases only. Experience of the first three months has clearly shown that there are a great many crippled men out of work who are anxious for advice and employment. Two hundred and twenty cripples, applying for work, have been registered during this three-month period. These men have been referred to 355 positions and 123 placements have been definitely made. The aim is to secure positions which will be permanent and constructive, rather than merely to place many men.

Applicants for work are referred to the bureau in many ways. A great many of them hear of the work through newspaper publicity, others are sent by the Workmen's Compensation authorities, by other employment bureaus, by charitable societies, the hospitals, the municipal lodging house, and still others come through cripples who have themselves been placed. Each week the number coming into the office increases.

Every applicant for work is registered carefully and an effort is made to find out just what kind of employment he wants. It is pointed out to him what lines of work will be injurious in consequence of his type of handicap. The hospital he is attending is consulted for a record of his disabilities, and, where possible, the physician in charge of the case is asked to advise what work is suitable. The man is questioned as to his work history in order to discover whether he has any experience of which advantage might be taken in planning his future occupational career. The endeavor is always to place the man where the work will be most congenial to him and where he can make the greatest use of his past experience.



The printing class at the Red Cross Institute for Crippled and Disabled Men.

tion. He later rose to be speaker of the house of representatives in his home state, and is now president of a flourishing bank in the middle west. "If your mind and spirit are straight," he says, "no other handicap can keep you down."

The next speaker had had one leg amputated and started under this handicap with no educational or financial advantages whatever. The best job he could get was as a shipping clerk, but he soon found there was no future for a disabled man in a manual and unskilled job. Under great difficulty, he attended night school, and finally obtained modest employment under civil service auspices. He now occupies a position requiring a high degree of alertness and experience.

The last speaker lost both arms in an accident; one is amputated at the shoulder, the other just below the elbow. He found almost hopeless difficulty in getting the first job, becoming meanwhile almost a vagrant. At last he obtained employment supervising a gang of unskilled laborers. From that point he has risen steadily. He has in-

After there has been made analysis of the work suited to the applicant, the task is to get him a job. One method of securing employment is through letters in the newspapers and other forms of publicity. Many employers are now prejudiced against cripples, and it is a difficult task to create a real demand for them. It is felt, however, that, if there can be discovered, through a careful study of industrial processes, just those niches in which a cripple can be as useful as a normal man, the department can in time get employers to call on it when they can use cripples. They will realize that the effort is not to foist upon them unplaceable applicants, but to do a truly scientific job of placement. It is encouraging to note that, in the first week of its operation, the institute bureau had six calls for workers. During a recent week, seventeen employers called on us for help and were willing to take cripples.

A great many of our positions are secured through the cooperation of the State Clearing House for Employment Offices. All calls open at the non-commercial agencies throughout the city are listed by the clearing house and are transferred to any bureau which has a suitable applicant. The department keeps a list of all employers who have ever used its services, and, when there applies a man who seems adapted for a particular kind of work, we call up the appropriate employer and try to interest him in the applicant.

After a cripple has been placed, there is made a real effort to keep in touch with him. Occasionally, his home is visited and, in some cases, the employer is interviewed after the man has been employed about a month. One evening office hour is held each week and the most effective follow-up work is done at that time. At a recent evening office hour, thirteen men called to report how they were getting along at their jobs. Many little readjustments while at work can be made in this way.

SURVEY OF INDUSTRIAL PROCESSES

There is being made an industrial survey in order to discover what are the best opportunities for cripples in the industrial field. This serves a double purpose in that it is productive not only of the theoretic knowledge, but also the actual positions in which cripples can be placed. When the field workers make their calls, they ask whether the individual employers can use any of the applicants registered as seeking work.

For this survey, there have been listed the larger industries in Greater New York and selected for investigation those which seem most suitable for cripples, such as the shoe industry, leather goods manufacture, piano action work, toy-making, and cigar factories. In each industry, the field worker visits the manufacturers' association, the trade union secretary, the trade journal editor, and a number of typical factories. The facts gained in these investigations are checked or neutralized by the experiences in these trades of the crippled workers, careful record of which is also kept. When these facts are all brought together, it is planned to give them publicity, so that each manufacturer will be induced to see just where he can, without detriment to his business, make use of cripples in his employ.

There are many discouraging features in the work of finding employment for cripples. The employers are prejudiced and there is often but poor material to offer them. Eventually, however, it is hoped that the department will be prepared to deal with every type of cripple and give him really scientific aid toward securing the best kind of job.

[To be continued.]



A Plea for the Hourly Nursing Service as a War Measure To the Editor of THE MODERN HOSPITAL:

The idea of an hourly nursing service is not new. Hourly nursing has proved itself successful over a period of years in our large cities. Since its former success augurs well for its future success on a much larger scale, let us see if this form of nursing service to the rich and middle classes would answer in some measure the needs in the private homes and in the hospitals.

Many private-duty nurses have not yet responded to the call from the surgeon-general's office. Many hospital nurses and many public welfare nurses answered the call to the colors during the first year of our engagement in the war, but in almost every case to the detriment of the institution or the organization they represented, since both classes of workers represent assimilative and absorptive processes in the formation of the aims and ideas of either class of organization.

It is true that large numbers of private-duty nurses answered the call to the colors. It is true that they are still answering the call, but not yet in sufficient numbers. How does the hourly nursing service solve the problem now confronting us?

In several ways. First, the private-duty nurse is more easily adjusted to the national service than any other woman in the profession, being more or less of a free lance as to the disposal of her time, her work, and her freedom. Is she ultimately through her present program meeting the great economic problems of the masses? The private nurse has met a need in the private home and she has discharged that need splendidly, but she has also been a luxury to the individual patient in many instances. Now that the days of selective and individual luxury are no longer fashionable, is it not time for the people themselves to forego a luxury, that the army may secure a necessity? How, then, may the private patient in his home receive adequate care? Here is the place for the ample use of the Red Cross home nursing course. Here might be the fulfillment of its primary object, the care of the sick in the home. The graduate nurse, spending one or more hours, can give important and necessary treatment in the home and through the hourly nursing system care for a number of patients a day. The family, taking its orders from the doctor and the graduate nurse, cannot deviate very far from the proper course, for in this day of telephones the nurse can easily be reached or recalled. With a suitable fee adjusted by the hourly nursing department of the registry, a graduate nurse can earn easily as much a day and week as by doing strictly private nursing.

Through this method, older women in private duty and not physically fit for war service can give valuable if not larger service to the people of both the rich and the middle classes who are now clamoring for private nurses. Private nursing would thus fall into two classes of service: the care of the acutely ill and the care of milder

forms of disease. The acutely ill will need the constant services of the nurse, but the minute that the disease takes the milder course the private-duty nurse should be released and hourly nursing instituted.

In the hospitals many patients would do quite as well if they shared in the time and expense of a nurse with other patients. One graduate should take ample care of two patients recovering from the milder forms of surgical procedure. It is well known how often the graduate nurse puts in time in convalescent nursing. In normal times of peace one would hesitate to make comment, but in war where every nurse must weigh the matter on the altar of conscience, duty, and patriotism, she should hesitate long in these days before she becomes willing to spend precious hours crocheting through the convalescent period of the mild illness of her patient.

It is safe to assume that our private families are willing to make the sacrifice. Knowing that nurses are at hand for hourly work and that the necessary and major treatment can be given by the hourly nurse, they will no longer hesitate to serve the meals and wait on their loved one, if thereby more nurses and yet more nurses are released for service with our soldiers. The hourly nursing system could be adjusted to hospital conditions also. The great cry for private nurses with our hospital patients has been justified in a large measure, since class work and demonstration work has prevented uninterrupted service from the student nurse on duty on the private floor. With the main treatment given, however, an acutely ill patient would receive ample and adequate care, and in the main would be satisfied. The alternating service of one graduate nurse for two private patients seems to be perhaps a better program for the acutely sick in hospitals, while the hourly nursing program in many cases is also entirely feasible.

I believe that we shall ultimately have to resort to some method in order that the best nurses this country has to offer shall be found with the boys at the front and in our cantonments. Why wait? The need is now. The loyal physician, the loyal hospital, the loyal family, can easily make this adjustment. It should be done with care, through a well-organized registry, and it seems to me that by this process many women who are so dependent on private nursing as their only outlook will get the larger point of view and enter their country's service.

If this cannot be done as an issue to meet an issue, then, nurses of America, let us do no less than our men have done. Let us be willing to be sorted out and when sorted let us not be found wanting.

The call is here and the time is NOW.

ELEANOR E. HAMILTON, R.N.,
Dayton, Ohio.

No pleasure is comparable to the standing upon the vantage ground of truth.—Bacon.

"Speak thou the truth. Let others fence

And trim their words for pay;

In pleasant sunshine of pretence

Let others bask their day.

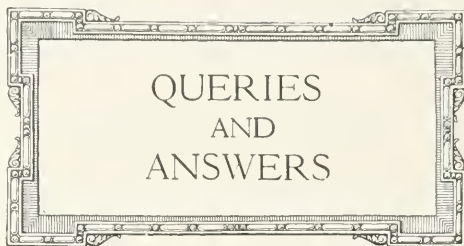
Guard thou the fact: though clouds of night

Down on thy watch-tower stoop,

Though thou shouldst see thine heart's delight

Borne from thee by their sweep."

There would be more sunstrokes in the world if it were not that the shadows of dull men made nice cool places for the others to walk in.



The Dietitian Problem in the Small Hospital

To the Editor of THE MODERN HOSPITAL:

I have read and reread the interesting discussions of the subject of hospital standardization in the *Bulletin of the American College of Surgeons*, and in connection with Dr. Hornsby's talks on dietitians I decided to ask for opinions on my own ideas of this subject.

The well-trained dietitian is a scientific person, and as such is very valuable, yet in a hospital of the size of mine, forty to fifty patients, we have not felt able to afford to ask only scientific work of the dietitian, and yet the combinations so far have not been satisfactory. We have tried the combination of dietitian-housekeeper, and I am sure it has many disadvantages, especially in this day of inefficient and insufficient help.

Now I am wondering if the combination of dietitian and laboratory technician would be practical, and if there is a dietitian who would give it a trial? To make these separate positions in a small hospital and afford the salary to each to insure efficiency is almost impossible, yet it seems to me if the dietitian were relieved of some of the present practical unscientific work, she would be able to accomplish the scientific work connected with each position.

A rough idea of the duties of the position would be: to make out or supervise all menus, to meet the physicians to discuss special diets, to supervise the preparation of special diets, to do routine laboratory work and history-taking, and to instruct the pupil nurses in dietetics and bacteriology. It sounds like a medley, I will admit, yet, considering that many times we are caring for as low as twenty patients, it is not so bad as it looks. I would certainly appreciate hearing how some of the other hospitals of the size of this are arranging to meet requirements along these lines.

I felt very guilty when I read of Dr. Hornsby's disgust when he found the dietitian attending to "getting out the trays for the private patients," yet I know many times our dietitians have been doing just that. I hope that Dr. Hornsby will give his opinion on a way out for the small hospital.

PERPLEXED.

Your idea of the combination of dietitian and laboratory technician is not at all an impossible one, though at present it is not usual. Many college graduates with a good and fairly thorough knowledge of chemistry and bacteriology are becoming dietitians. In cooperation with a medical man who is able and willing to follow up accurate laboratory methods, such a dietitian-technician could be of great value to a hospital, especially one of the smaller institutions. Unfortunately the other combination to which you refer, dietitian and housekeeper, has been more common and does not appeal to our better-trained women.

Not until the hospital is willing to give proper recognition and authority to the dietitian will this work attract the more efficient women. It is quite certain that in this formative period in the specialty of dietetics, each small hospital must be a law unto itself and meet the problem with the personnel available. In some cases even an intelligent well-educated woman who has had no special training will be able to make use of one or more of the many available text-books and draw on her own native wit and resources, drawing also on the help she can get from members of the hospital medical staff.

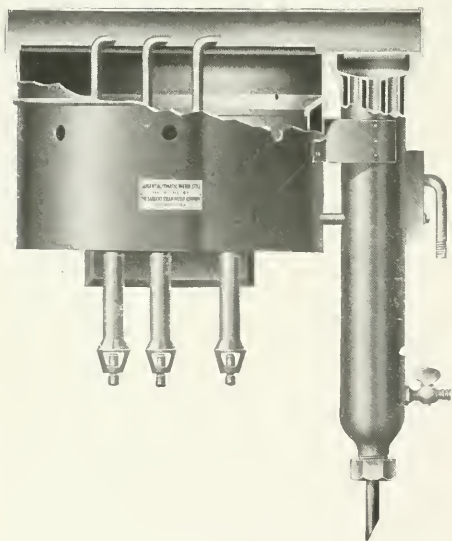


VINCENZ MUELLER, Technical Editor.
GEO. W. WALLERICH, Associate Editor.

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast avenue, Oak Park, Illinois.

The Sargent Water Still

Most authorities are agreed that, for medical purposes, pure water is preferable to the so-called medicinal spring waters, for the reason that all of the latter contain more or less impurities in the form of salts or organic matter, which is not the case with distilled water. Distilled water is considered absolutely pure, no matter how foul the water may have been from which it was obtained.



Sargent still for producing pure water for drinking or culinary purposes.

The manufacturers of the Sargent still are producing a number of different apparatus, suitable for home use as well as for use in industrial plants, sanatoriums and hospitals. In smaller institutions which are not equipped with steam plants an automatic still is recommended. This is connected up to running water, to a sink for the overflow, and to gas. The distilled water may be piped into a 5-gallon jar or half-gallon bottle, just as desired, and no attention need be paid to the still after starting, except to remove the full bottle of *aqua pura*. Such a still has a capacity of 2 gallons per hour at a cost of 2 cents per gallon.

For large hospitals or industrial plants where great quantities of drinking water are consumed and where steam is available, the steam-operated automatic still is recommended, having a capacity of from 2 to 10 gallons per hour. This still will furnish drinking water for 30 to 50 people in the hottest weather. Where electric current is available at from 2 to 4 cents per kilowatt and gas is not obtainable, electric stills can be furnished.

The Sargent still is well made of heavy cold-rolled spun copper and lined with block tin. The manufacturers are willing to guarantee that this apparatus will furnish for drinking or culinary purposes aerated distilled water free from all microbes, injurious gases, or mineral salt.

The "Verithin" X-Ray Cassette

The construction of various types of cassettes vary. The average cassette is so thick that it is an uncomfortable object for the patient to lie upon. The McIntosh "Verithin" Cassette is extremely thin, as the 8 by 10 inch size is only 5/16 inch thick; while the 11 by 14 inch and 14 by 17 inch sizes are 7/16 inch thick.

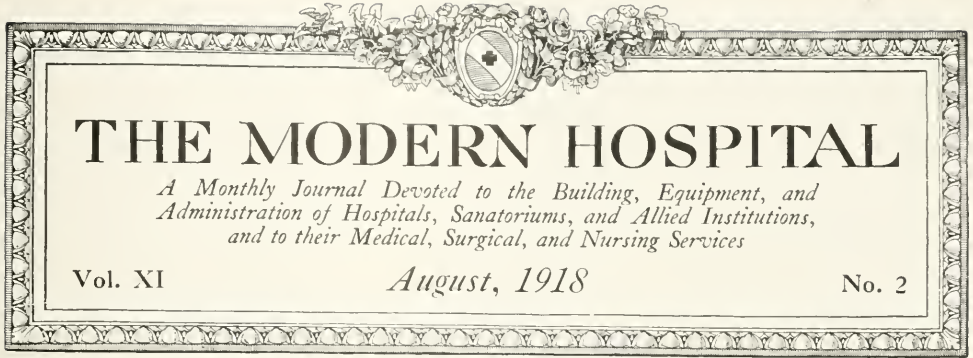
The illustration shows the ease with which a plate may be removed after an exposure without lifting it with the finger-nail or scratching the film, as with other types of cassettes. An aluminum spring flap underneath the plate may be raised by inserting the finger in a hole underneath, thus raising the plate. When closed the aluminum flap



McIntosh "Verithin" cassette, illustrating ease of removal of plate.

covers the hole, making it light-proof. Many cassettes are extremely awkward to manipulate, especially in the larger sizes, some of them being almost impossible to close even with both hands.

This cassette is reversible. Exposures can be made from either side. The walls are of sheet aluminum, offering practically no resistance to the x-ray. The intensifying screen, when ordered with cassette, is mounted in the upper panel, so that when it is raised, no obstruction is present to the removal of plate; neither is there any chance of scratching the screen, as is the case when the screen is placed underneath the plate. A simple, but effective clasp closes the cassette tightly. Operators who do a great deal of work and realize the annoyance of manipulating an inconvenient cassette in darkness or semidarkness will welcome this improvement as worth many times the small cost of the device.



THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to their Medical, Surgical, and Nursing Services

Vol. XI

August, 1918

No. 2

STANDARDIZATION OF STATE HOSPITALS*

Public Charitable and Penal Institutions a Part of the Hospital System—An Ideal of Purpose and Object—Some Suggestions in Regard to Constructions—Hospital Wards and the Chronic Patient—Follow-up Service and Out-Patient Clinics—Elimination of Waste

By A. L. BOWEN, SUPERINTENDENT OF CHARITIES, DEPARTMENT OF PUBLIC WELFARE, SPRINGFIELD, ILL.

IN all that has been said and done in behalf of better hospital standards, the state hospital, the private sanatorium for mental and nervous diseases, and those state eleemosynary institutions in general which involve more or less of medical and surgical treatment and research, have been given scant consideration.

THEY ARE JUST AS IMPORTANT

In my opinion they are quite as worthy of attention as the general hospital; I am sure they are as important in every respect; they represent vast investments of capital; they require tremendous sums for maintenance; they minister to rich and poor at the expense of the taxpayer; they are concerned with problems of disease and social conditions infinitely more complex than any of the physical diseases which receive attention in general hospitals; their patients are as numerous as the patients of the general hospitals, and their burden upon the lives and resources of our people forms the biggest single item in the tax budget. Moreover they are subject to sinister and distracting influences, peculiar to themselves, which tend to the demoralization of organization and paralysis of effort.

ALL ARE PLACES FOR CARE AND TREATMENT

Reduced to simple terms, our state charitable, correctional, and penal institutions are all places

of care and treatment in which medical science plays the leading role. They differ from general hospitals only in methods, application, and technique. All of them must care for acute and chronic physical sickness among their inmates. All of them must, or should, practice surgery. All of them require skillful nursing and competent medical officers. Mental and nervous cases present additional medical and psychological problems, and the neurologist, psychiatrist, and alienist are essential. The mental nurse, in addition to regular "R.N." training, must have had psychiatric theory and practice. To these patients we should bring the psychologist and the occupational therapist. The research field here is unlimited.

In correctional institutions we have present, in addition to the physical ailments, delicate and complex mental phases, quite distinct from those found in the hospitals for the insane and the colony for feeble-minded, but none the less mental in character.

Children's institutions offer another line of work, involving education, which even among so many of the so-called normal dependents, must be given by methods different from those in vogue in public schools.

CONSIDER THE STATE HOSPITAL ALONE

The whole system of public charitable and penal institutions should be considered as a hospital system; the day is near when it will be so thought of. But I want to confine this article to the state hospital—the institution where the state is supposed to be caring for and treating the insane.

*This paper is the fourth in a series, by various authors, on the standards of the various classes of special hospitals. The first, "Standards for a Children's Hospital," by Stafford McLean, appeared in May; the second, "The Standards of Hospital Education for Interns," by J. M. Baldy, was published in June; and the third, "The Standardization of Hospital for the Insane," by William C. Sandy, was published in the July issue.

With few exceptions these institutions do not deserve the name "hospital;" it has been applied to cover up deficiencies; it is also a milder and gentler term than "asylum," its much-beloved predecessor.

PLACES OF DETENTION WITHOUT IDEALS

Taken the country over, these institutions are places of detention without standards or ideals. In nearly all states they are a part of political machinery. Superintendents and employees are payroll patriots, more engrossed with the business of keeping the party or organization in office than in doing something for their patients or studying means for relieving the taxpayer. It is not necessary to go into detail as to conditions which exist; they are well understood.

The remedy lies in publicity; in presenting to the public and to officials, some ideals of state hospital service and offering a standard which every state hospital must attain or be characterized as unfit and unworthy either of confidence or of taxes.

AN IDEAL OF PURPOSE AND OBJECT

Any scheme of standardization of state hospitals must first of all submit an ideal, not an ideal of physical plant or of medical staff, or of internal management and policy, but an ideal of object and purpose. What has the state hospital been created to do? What are its functions in society? Is it to be a hospital in the true sense, offering not alone medical and surgical service, but also reeducational advantages, occupational therapy, employment to the patient and to the professional man—a scientific field of the highest type, whose objectives are not limited to the institution, but extend into the community and ramify all its activities?

The expression of ideal of purpose and object must be followed, of course, by the organization of minimum requirements of service.

SOME STRUCTURAL SUGGESTIONS

The structural conditions are important but not determining. The very best service in the world may be housed in a structure long since considered antiquated as to plan. There is no reason why the congregate institution may not furnish its patients and the public very excellent service, even though this style long since ceased to be considered first-class. But, for future construction and expansion, a minimum standard can easily be submitted. Personally, I believe in the small one-story dormitory cottage with few single rooms, ample toilet and bathing facilities, unbarred windows, and, so far as possible, unlocked doors. For

the thousands of chronic insane who are to spend their lives segregated, this type offers the most advantages and the maximum of liberties; it allows a nearer approach to natural life; and this must always be kept in mind when thinking on this subject: the institution should always aim at the reproduction, for its inmates, of conditions and situations as nearly natural as it is possible to attain. True community life is possible in an institution, but we have not yet been able to supply it in a degree that demonstrates its possibilities.

All classes of employees should be trained and experienced to furnish intelligent oversight and supervision and to become human substitutes for bars and locks. That this can be done has been proved too many times to permit us to waste time discussing it academically.

The state hospital standard should provide full-time resident physicians, dentists, pathologists, psychologists, occupational therapists, directors of recreation and amusements; it should require modern hospital equipment and facilities for the physically sick and infirm; hydrotherapeutic wards, for such acute and chronic disturbed patients as are benefited by hydrotherapy, such wards to be in operation the full twenty-four hours of each day and to be in charge of trained hydrotherapists.

Mechanical restraint is wholly unnecessary and should be excised by the force of public opinion wherever state hospital authorities refuse or neglect to govern themselves and administer their institutions by the light of so sensible and so humane a requirement.

SERVICE TO THE PATIENT

Service to the patient should include modern diagnostic methods on his admission, both as to his mental and his physical state, followed by frequent progress notes and by at least two complete mental and physical examinations each year throughout his entire residence in the institution. Only by such follow-up service can the staff know its patients and the patients be given the chance and the opportunity for betterment of environment, whether in the hospital or on the outside. Many patients today have degenerated in the institution, and the time has passed when they might have made good in free life.

HOSPITAL WARDS AND THE CHRONIC PATIENT

Wards for the sick and infirm should be in charge of registered nurses, and those for the chronic insane in charge of trained attendants drilled in specific duties towards their patients. To secure such types, the institution must main-

tain in its own walls a training school for nurses and attendants, and it must affiliate with schools and general hospitals conducting training courses for nurses for general practice. There should be an exchange of the pupil nurses between the two types of schools and institutions. For after this war no registered nurse's education will be complete without a greater or less amount of instruction and experience with mental cases.

Employees should be housed off the wards in buildings planned to provide comforts and social relaxation under wholesome influences. The eight-hour shift should prevail. Women attendants on male wards are preferable to men, who should be employed only to do the shaving and bathing and as night watches.

FOLLOW-UP SERVICE AND OUT-PATIENT CLINICS

A minimum standard will require follow-up social service for the convalescent and the paroled patient. It will provide a free dispensary, or out-patient clinic, in the larger towns of the district which the hospital serves, where staff physicians on stated days can be consulted by those feeling the need of expert attention and advice, and by the paroled patient.

Experience, based on actual experiments conducted in many hospitals, convince us that so-called "untidy" wards, "disturbed" wards, and the like are absolutely unnecessary. I believe they are a reflection upon your ingenuity and intelligence. Reeducational methods, employment, and occupation are all available for the treatment of these classes and accomplish wonders when rightly applied.

Screen rooms are relics of barbarism and no standard should countenance them or excuse them.

SOME PHASES NOT TOUCHED

I have not touched on diet and the serving of meals, or on safeguards against fire and accidents, or on the controversy between the ward and the congregate dining room, or upon the very important matter of records, or upon many other points which should be considered vital details worthy of settlement or suggestion in any standardizing which might be undertaken.

What I have suggested does not form a complete standard even on those phases which I have touched. I have hoped that what I might write here would furnish the basis for discussion from which may develop better things: I might hope that it will be the root from which will spring an organized effort for improvement, such as has done so much already for the betterment of general hospitals throughout the whole country.

Someone will reply that even this much is too elaborate and too expensive, but I say no. These institutions are operated by the state on the people's money. It may seem impossible, but I make the assertion that a standard based on these suggestions will not cost the people a material addition to what it now costs them.

ELIMINATE WASTE—PROVIDE SKILL

When the waste involved in the political or partisan system of management is eliminated; when buildings, improvements, and supplies are furnished on merit and business principles, and not on political expediency; when the employee is trained for his specific duty and is paid well enough to enlist and retain his services, thereby eliminating the wasteful labor turn-over; when the able-bodied patients are all engaged in some economic employment; when supervision of food, its preparation, distribution, and serving is skilled, thereby cutting out waste; when the power plant has been modernized with labor, fuel, and heat saving devices; when the medical staff is professionalized and engaged strictly in the profession of returning patients to society and averting mental breakdown by treatment in the home; when these changes, and many others which logically follow them, take place, as they certainly will when a standard is set by men and women of national voice and appeal—then the state hospital will give service and promote a spirit of ideals at an expense no greater than it now imposes upon the taxpayer with no more return than a common jail is expected to make.

Speaking at a meeting of the Church of England Zenana Missionary Society on May 3, Dr. Charlotte Bacon, of Kevelin, China, described the methods of the Chinese "quack" doctor. Has the patient a pain?—then stick a needle in, no matter where the pain is. Has he an abscess or boil?—then plaster it over with dirt and mud to keep the smell in. If feeling a pulse, feel *both*, for one tells the condition of kidneys and stomach, and the other of lungs and heart! Dr. Bacon's first operation was for trachoma; three friends came with the patient, and two Chinese women were beginning to be taught as nurses; but when the doctor put out her hand to take a swab from the bowl that one should have been holding, there was no bowl there. Friends and nurses had fled at sight of the first drop of blood! The little hospital now has only ten beds, but it sometimes holds twenty patients, as well as their friends. "Do you wonder," asked Dr. Bacon, "that sister's face was very long when first she saw my hospital?" This same sister is now carrying on single-handed till Dr. Bacon can return, the only worker with medical knowledge in a city of 250,000 inhabitants.—British Journal of Nursing.

No wind serves him who addresses his voyage to no certain port.—Montaigne.

THE NURSES' HOME OF THE HACKENSACK HOSPITAL*

An Attractive Building in Georgian Style—Brightness and Cheer the Dominant Notes—A Generous Gift to the Community

BY FREDERICK P. WASHBURN, PRESIDENT OF THE HACKENSACK HOSPITAL ASSOCIATION, HACKENSACK, N. J.

THE nurses' home of the Hackensack Hospital is of stone and brick fireproof construction. It stands south of the hospital in a commanding situation, with an extended view to the east. The architecture is Georgian in style, and the interior

a resident instructor, for the instruction of nurses under training. It is equipped with pupils' chairs, instructor's desk, and blackboard. Adjoining this room is a "demonstration room" with two manikins upon separate beds. A more interesting and inviting apartment comes next—the diet kitchen, where pupils will be taught how to prepare dainty dishes in an endeavor to lure back vagrant appetites. This room is fitted up with individual gas appliances, also a gas range, and pots, kettles, and pans that tell the story of a real housekeeper's supervision of selection. Here is another blackboard where the demonstrator is presumed to give free-hand drawing of calories and other mysteries entering into balanced rations for invalids and for convalescents who manifest the appetites of growing boys in baseball time. The laundry, trunk-room and heating plant are also on this basement floor.



Fig. 1. The nurses' home of Hackensack Hospital, a structure in Georgian style.

decorations are also Georgian. The elegant and graceful simplicity of the structure is most creditable to the architects, Crow, Lewis, and Wickenhoefer of New York.

Comely proportions and harmony are conspicuous throughout the interior. Each floor has a wide hall running the full length of the building, which is 85 by 36 feet, and windows at each end give ample light even on cloudy days. Brightness and cheeriness dominate every part, insuring to nurses off duty absolute relief and rest from the trying tasks in the adjoining hospital; and, in furtherance of this desirable purpose, particular attention has been given to making the place as sound-proof as possible, for some of the nurses must always be sleeping by day.

The business part of the establishment is in the basement. Here is a classroom, in charge of



Fig. 2. The main entrance of the Hackensack nurses' home.

*This is the seventh in a series of articles on nurses' homes. The first, "Nurses' Homes and Some of Their Requirements," by Olof Z. Cervin, appeared in January; the second, "Kistler Memorial Home for Nurses of Lock Haven Hospital," by V. Happersett and Louis H. Rush, in February; the third, "New Nurses' Home for Minnequa Hospital, Pueblo, Colo.," by R. W. Corwin, in March; the fourth, "The Helen Newberry Nurses' Home," by Harriet Leck, in April; the fifth, "The Nurses' Home of the Norton Memorial Infirmary," by Arthur Loomis and Julius Hartman, in May; and the sixth, "Nurses' Homes—A Plea for Efficiency in Their Design," by Meyer J. Sturm, in June.

The main (entrance) floor has a suite of rooms for Miss Stone, superintendent of the hospital, a general writing room, a library, and a large living room extending across the south end and opening on to a large sun-parlor, heated in winter and screened in summer. There is also a reception room and several bed-rooms for nurses on this floor. The living room is handsomely furnished,

with a gas jet in each. Accommodations are provided for thirty-four nurses.

On the upper floor there are two isolation rooms for use in case nurses should have contagious diseases. Each room has a commodious closet. Then there are large linen closets, well stocked and with each article carefully marked with the name of the home.

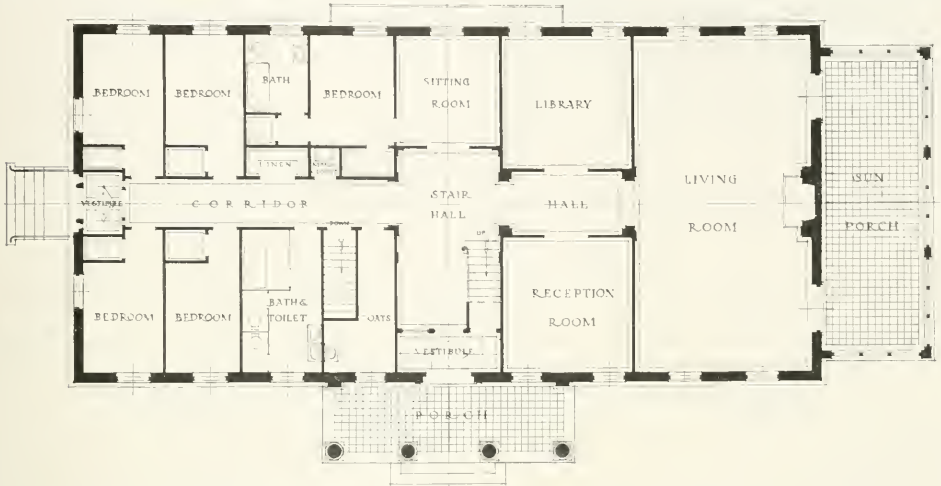


Fig. 3. First floor plan of the Hackensack Nurses' Home. The building is 85 by 36 feet.

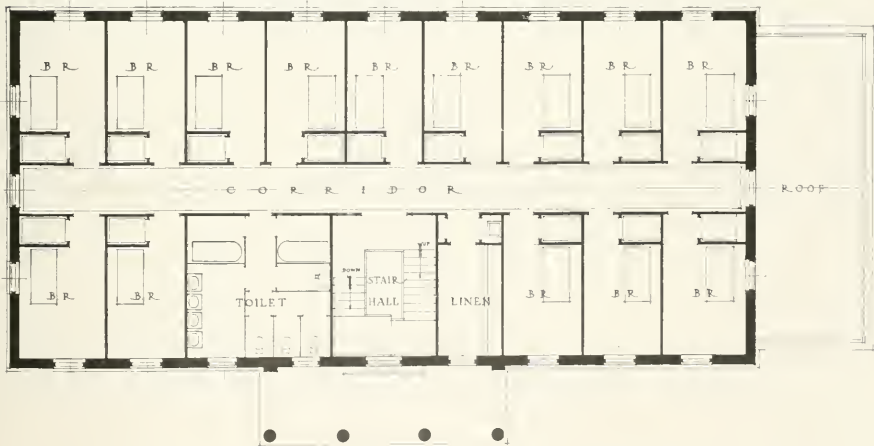


Fig. 4. Typical bed room floor plan of the Hackensack nurses' home.

the furniture being the gift of Theodore J. Palmer and his son Embury Palmer of the firm of Palmer & Embury, New York.

Each of the nurses' rooms is furnished complete to the minutest detail; this includes writing desk and embossed stationery. The rooms are lighted by electricity and there is also a conven-

ient gas jet in each. Accommodations are provided for thirty-four nurses. There are lavatories, baths, and showers on each floor, all equipped in the most thorough manner. In fact, there appears to be no detail overlooked in making this a complete home for the large corps of faithful nurses employed in the Hackensack Hospital. With the exceptions noted, the substantial construction and finish, and the com-



Fig. 5. Living room in the nurses' home.

plete furnishings of the home, ready for the nurses to move into with their personal belongings,

are due to the generosity of the Hon. William M. Johnson. He not only expended about sixty-five thousand dollars in making the building one of the most complete of its class in the country, but has given to the Hackensack Hospital Association bonds of the value of forty thousand dollars as an endowment of the home, the income to defray the expense of its maintenance. This relieves the hospital from all care for supporting the institution—a free and clear gift.

A more comfortable and inviting home for the hospital nurses could not well be conceived. Nor can it fairly be doubted that they deserve such a retreat to which they may retire when off duty, free from the cares and trials of sick rooms. Here they may thoroughly enjoy the recreative hours in absolute rest, with attractive surroundings that include "all the comforts of home."

METHODS OF INDEXING HOSPITAL CLINICAL RECORDS

Wholesome Influence on Hospital Work of Adequate System of Indexing—Two Methods of Filing Histories—Card Catalogue of Diagnoses and Self-Indexing History File

By MIRIAM BYRNE, MEDICAL RECORD CLERK, COOK COUNTY HOSPITAL, CHICAGO

WITHIN the last decade, many hospitals have awakened to a realization of the value of clinical records for research and teaching purposes. This has come not only to the large hospitals or to those close to the teaching centers, but to the smaller and more remote as well, and the results in improved hospital conditions and better hospital work have been noteworthy; for, whenever the question of conserving records is discussed, the question of the value of such records arises, and to the problem of finding the best method of filing is added that of seeing that the records are worth filing. The fact that no record is worth filing unless it shows every detail, pathological and clinical, which may have affected the progress of the illness, and the knowledge that every record is liable to close and intelligent scrutiny have a marked retro-active effect in promoting more thorough examinations of all kinds and care in the record-building. This wholesome influence on the work of the hospital in general exerted by formal indexing of clinical records carried out in suitable surroundings is very evident in some of our better-conducted hospitals.

There are many factors to be considered in the proper conserving and utilizing of history sheets, but it is the purpose of this article to consider methods of filing only in so far as they bear on the accessibility of records for medical research. There are two methods of filing histories with this

object in view. Under one the diagnoses are indexed on cards, and under the other the histories themselves are filed according to diagnosis. The first method was used at the Cook County Hospital during 1909 and 1910, but, owing to the great demand for large numbers of histories and to the small amount of clerical service available, the other method was installed in January, 1911. As this latter method makes it possible to take out and replace all the histories of any disease or condition in the time required to pull out the drawer containing them, without any preliminary listing or choosing, the attending and resident physicians have used the records very much more than when it was necessary to list and assort records and wait until they were taken out of the files. Having used both methods and realizing the meagerness of information in regard to this phase of hospital work, I have prepared the following brief outline of both and compiled a list of all references in English to clinical indexing of hospital records which a thorough search discloses.

CARD CATALOGUE OF DIAGNOSES

When the clinical catalogues consist of cards, the history is filed numerically according to the patient's admission number and a card is written for each disease or pathological entity by which the patient was affected while in the hospital. For instance, Mary Brown, who was treated for scar-

let fever complicated by acute nephritis, would have two cards in the diagnosis catalogue. The scarlet fever card, as illustrated in Fig. 1, would be placed in its correct chronological order behind the guide card for scarlet fever, and a card for acute nephritis (Fig. 2) would be similarly placed behind the acute nephritis guide. Anyone wishing to look up all histories of scarlet fever, all

second "Diseases of the Blood," the third "Diseases of Bones and Cartilages." In the second drawer, which is labeled "Diseases of the Blood," are placed guides with the subject headings:

Anemia, Pernicious.
Anemia, Simple.
Anemia, Splenic.
Chlorosis.
Hemophilia.
Leukemia.

In back of the "Pernicious Anemia" guide are placed the pernicious anemia histories in order of their arrival in the record room and according to the serial number of that disease. On the history of John Smith, whose case was the fifth of pernicious anemia, appears "Pernicious Anemia, File No. 5," and on the card filed alphabetically under the name "John Smith" appears "Pernicious Anemia No. 5."

For the indexing of complicating diseases, the forms illustrated in Figs. 3 and 4 are used. These forms are the same size as the history sheets and

Principal Disease	
Complications	
Name	File No.
Age	
Dates	
Condition	Dr.

Fig. 1. Specimen card used in the card catalogue of diagnoses. This card, used for the principal disease, is a white card measuring 3 by 5 inches.

complications of scarlet fever, all acute nephritides, or nephritis as a complication of scarlet fever, makes a list of the hospital admission numbers appearing on the proper cards.

Even after this preliminary selecting and listing, the finding and removing of the needed histories from the filing cases is a tedious process, and when the researcher has finished his work there remains the task of replacing them one by

Complication	
Principal Disease	
Other Complications	
Name	File No.
Age	
Dates	
Condition	Dr.

Fig. 2. Specimen card for the complications in the card catalogue of diagnoses. This is a blue card measuring 3 by 5 inches.

one. For whatever length of time anyone working on a group of histories keeps those histories out, the files are incomplete and disarranged.

HISTORIES SELF-INDEXED

Under the other method, which originated at Bellevue Hospital and is known as the Bellevue Hospital System, the histories are placed in vertical filing drawers behind guides arranged according to an accepted nomenclature. If the Bellevue nomenclature is used, the first drawer is labeled "Abnormalities and Congenital Malformations," the

COMPLICATIONS OF		From Jan 1 st 1915 To Jan 1 st 1916
Pernicious Anemia		
Name of Complication	History Number of the Disease named Above	
Acute Otitis Media	58-	
Alcohol Intoxication	62-65-16	

Fig. 3. Form used for indexing complications of a given disease according to the self-indexing system of filing histories. This sheet corresponds in size to the history sheet.

are kept in manilla paper folders and filed with the histories. The two folders containing the sheets entitled "Complications of Pernicious Anemia" and "Complicating Disease—Pernicious

CROSS REFERENCE SHEET		From Jan 1 st 1915 To Jan 1 st 1916
NAME OF COMPLICATING DISEASE		Acute Otitis Media
Name of Disease Complicated	History Number of Diseases named Below	
Pernicious Anemia	58-	
Scarlet Fever	36-452-224-	

Fig. 4. Cross reference sheet for use in the self-indexing system of filing histories.

Anemia" are placed directly in front of all the pernicious anemia histories and directly behind the guide card labeled "Pernicious Anemia."

Anyone wishing to see the records of any disease or condition finds them all in one place with supplementary lists already prepared and available at a moment's notice. It is not unusual for a researcher to refer to groups of histories sometimes totaling several hundred again and again during a period of many months, and under this method a whole group or any part of it may be taken out and replaced daily and the files kept complete and in good order.

NOMENCLATURE

Although absolute uniformity in the terms employed in diagnosis is recognized as essential in medical statistical inquiry, it is a regrettable truth that the various hospitals which have attempted to use their records for research purposes, instead of adopting some one nomenclature and making it standard, have in almost every case compiled lists and arranged classifications of their own. The Bellevue Hospital Nomenclature, compiled in 1903, revised in 1909 and in 1911 again revised and made to conform to the International Classification of Causes of Death, is more universally used than any other. Because of this and its recommendation by the Census Bureau and by the committee on nomenclature and classification of diseases of the American Medical Association¹ it may be considered more nearly standard than any other list of diagnoses published in this country.

BINDING

It is customary at some hospitals to bind the histories at convenient intervals. The stacks of bound volumes make an impressive-appearing library, and the possibility of a record being lost or destroyed is lessened. The expense, however, is considerable, the bound volumes are not so easily handled as separate histories, and the frequent requests for histories in the same volume by different individuals is a marked disadvantage.

REFERENCES

A Description of the System of Recording and Filing Histories used in Bellevue and Allied Hospitals, New York, 1905.

Myers, G. W.: Care of Hospital Records—According to the Method of the Massachusetts General Hospital, Boston, Mass. (Internat. Hosp. Rec., 1911).

Whitney, J. L.: The Nomenclature and Classification of Diseases in Use in the University of California Hospital (Boston Med. and Surg. Jour., Nov. 18, 1915).

Kilgore, E. S.: Clinical Records in Relation to Teaching and Research—A Plan to Promote Conservation and Utilization of Material (Boston Med. and Surg. Jour., Nov. 18, 1915); Clinical Records (I)—Outline of Case Histories (California State Jour. Med., Nov. 1915); Clinical Records (II)—Blank Forms (ibid., Dec., 1915); Clinical Records (III)—The Later Clinical Notes and List of Abbreviations (ibid., Jan., 1916); Clinical Records (IV)—The Ward Reference Book (ibid., Feb., 1916).

Clark, Genevieve L.: Clinical Records (V)—The General Oversight and Filing of Records (California State Jour. Med., March, 1916).

Brotherton, James S.: Hospital Clinical Records (Jour. Am. Med. Assn., April 19, 1913, p. 1205).

Howland, Joseph B.: Hospital Records (THE MODERN HOSPITAL, November, 1914, p. 288).

Bell, J. Finley: Method of Keeping Case Records for Small Hospitals (Med. Lib. and Historical Jour., 1905, 111).

Myers, G. W.: Hospital Records in Relation to the

Hospital Librarian (read at the 14th meeting of the Medical Library Association, May, 1911).

Hollings, Byam: Record Keeping at the Massachusetts General Hospital (THE MODERN HOSPITAL, Feb., 1914, p. 94).

The Bellevue Hospital Nomenclature of Diseases and Conditions, 1903, Revised 1911, New York.

Manual of the International List of Causes of Death, Second Revision, Paris, 1909 (Government Printing Office, Washington, 1911).

International Classification of Causes of Sickness and Death, Revised by the International Commission at the Session of Paris, July 1 to 3, 1909, for Use Beginning January 1, 1910, and Until December 31, 1919 (Government Printing Office, Washington, 1910).

List and Classification of Diagnoses for Use in the University of California Hospital (University of California Press, Berkeley, 1916).

Classification of Diseases, Massachusetts General Hospital, 1916.

List of Diseases and Pathological Conditions, Stanford University Medical Department Including Lane Hospital, San Francisco Cal., February, 1913.

Post, Wilbur E.: A Classified Nomenclature of Diseases Designed for Use as a Diagnosis Index in the Central Free Dispensary, Rush Medical College, 1909.

Advanced British Dressing Station on Newly Captured Ground

In a very short time after the capture of new territory, not only do the infantry and the artillery move up to maintain the new position, but the first aid dressing stations also take their places on the newly captured ground.



Copyright Underwood & Underwood, New York.

In this New Zealand official photograph, an advanced British dressing station has been moved up and the wounded are being treated. The German prisoners help in bringing in the wounded. A view of a former "no man's land" is given.

Many are the beings in us that are never born; many the lives beating their wings against our bars, seeking a freedom we forbid. Until some enthusiasm asserts us, we do not realize how partially, how timidly we have lived. No longer let us keep self under lock and key, niggardly doling it out, but freely outgive it that at last we may attain full size.—Stephen Berrien Stanton, "The Hidden Happiness."

¹Introduction to Manual of International List of Causes of Death. Second Revision, Paris, 1909, Jour. Am. Med. Assn., July 8, 1911.

HAS EVERY HOSPITAL AN INHERENT RIGHT TO AN INTERN?

Misunderstandings by Hospitals in Regard to Internship—No Discredit Attached to Non-Approval for Intern Education—Duties Which the Hospital Owes the Intern

By J. M. BALDY, M.D., PRESIDENT PENNSYLVANIA BUREAU OF MEDICAL EDUCATION AND LICENSURE, PHILADELPHIA.

THERE are so many misunderstandings by hospitals in regard to the question of internship and their so-called rights in this matter that it has been thought worth while to discuss a few points relative thereto.

As a basis for a discussion it may be said that no hospital has an inherent right in the matter of internship any more than it has an inherent right to a superintendent, to a head nurse of its training school, to an engineer, or to a cook. Hospitals have the right to purchase the services of any one of the above mentioned employees. They have the right to purchase the services of an intern. In the case of the above-mentioned employees, if hospitals wish to secure an individual competent to fulfill the needs of that particular department, they must pay the price. It goes without saying that, if they need the services of an intern, they must pay the price. The usual price asked of a hospital for the service of an intern is his education, and consequently it follows as a corollary that any hospital that wishes to buy the service of an intern must be able to qualify on the possible educational points necessary for this purpose. In Pennsylvania the Commonwealth has laid down a very definite and positive standard, both as to equipment and as to educational advantages, to be offered in return for the service of an intern. It is therefore simply a question as to whether or not a hospital can pay the price, as to whether it has a right to an intern. There is no such thing as an inherent right, an assumption which is too often assumed by hospitals.

There is no great hardship to any hospital not being approved for intern teaching, even if it desires a resident physician on its service. There are a number of possibilities of fulfilling this need. The number of interns who are required to take a service in an approved hospital are only a portion of the total number graduated from the Pennsylvania schools in any given year. In addition to these there are a few graduated from schools outside of Pennsylvania who intend to take the Pennsylvania state examinations and practice medicine in Pennsylvania. The total number of these compared with the total number of students graduated in the country at large is probably not more than 10 percent or 15 percent, and hospitals not on the approved list have avail-

able for their services the other 85 percent or 90 percent of young medical graduates of the country. Furthermore, they have available for their services young men who have already spent a year of internship in an approved hospital and who are about ready to start the practice of medicine. Probably 50 percent of the graduates in medicine are boys of moderate means who have exhausted all of their available funds during the course of their education and who would be only too glad to accept the position of "hospital resident" for a year or two at a decent living salary, thus making it possible for them to extend their hospital experience, as well as to lay up a few dollars with which to assure themselves their first year's expenses when they start in to practice. This establishment of the salaried resident physician is peculiarly adaptable for hospitals not assuming the teaching function. From these sources any unapproved institution may draw, and in no way interfere with the ambition of the Commonwealth to secure for its coming practitioners the proper standard of practical education before they are allowed a free hand upon the community.

It is a grave question whether or not small institutions obtain any advantage from the service of an intern. Usually hospitals of from twenty-five to fifty beds are in small communities where the doctors of the medical and surgical staff are in close touch with the institution at all times; a phone leads directly to the office and bedroom of every member of the staff, with every member within such easy reach as to be able to be in the hospital as often as required. The almost usual routine of such a hospital, where an intern is employed, is that the intern is practically allowed to run the institution; as a matter of fact, he is there more for the convenience of the doctors than he is for the efficient working of the hospital. The salaried resident physician accomplishes the same result as does the intern and has the great advantage of allowing the institution to demand competency and the full time of the doctor for the service of the hospital. In a large number of these institutions the intern is allowed entirely too much freedom for the interest of the patients, and he receives little or no instruction from the medical and surgical staff.

Some of the most efficient medical and surgical

institutions in the state have been in the past years, and are at present, conducted without the service of any intern, and so efficiently is the service conducted by the closer personal attention of the medical and surgical staff that an intern would be considered a nuisance and in the way. Many such institutions seriously and rightly object to allowing a young man too much freedom in the treatment of the patients.

No discredit whatever attends any medical institution which is not approved for intern education. The reason dominating the desire of not a few hospitals for approval for the education of an intern is the fear that their non-approval means discredit. If one were going to give a contract for shovels and pickaxes, and sent his agent into the field to seek out and recommend to him such factories as could fulfill his demands, and this agent happened to go, among others, into the Carnegie mills, which were producing Bessemer armor plate for the navy, and, in rendering his report of available steel manufacturing plants to his employer for the purchase of pickaxes and shovels, failed to include the Carnegie mills, it could hardly be complained by the Carnegie plants that they were not included in the list so reported and approved, and that thereby they were discredited as a steel plant. It would simply mean that the Carnegie plants were not producing picks and shovels, and there would not be the thought in the mind of a single individual in the Commonwealth that the Carnegie plant was not producing competently that for which they were organized, namely, the production of armor plate. And so it is with hospitals. The Commonwealth is not seeking for armor-plate hospitals. It is seeking for and approving hospitals which have all the facilities, both physical and personnel, for the education of the intern on a certain standard; its approval simply means that such an institution fulfills that need, nothing more and nothing less.

Institutions have sought approval for intern education because of the fact that they have conceived that it may in some mysterious way interfere with their state appropriations. This again is a fallacy. The Commonwealth, in contributing money to medical institutions, is doing so on the basis of the charity work done by the institution for the citizens of this Commonwealth. That service is evaluated, not by the Bureau of Medical Education and Licensure, but by another bureau, the State Board of Charities, and the approval or disapproval of the Bureau of Medical Education and Licensure for intern education has no bearing whatever on the approval of the State Board of Charities for the amount of charity work done;

and no institution is in any way affected as far as its charitable financial work is concerned. As a matter of fact, if a weak institution which has become fairly competent in the carrying out of the one function which it was fulfilling were to take on the dual function (the additional function of education of the intern), it might readily become so inefficient in the conduct of its purely charity work as to weaken its claims on charitable funds for charity work performed.

It would be a grave mistake on the part of the state to demand that all hospitals accept interns into their service, especially after having laid down a certain standard as a minimum competent standard for instruction of the intern. Hospitals are usually established by their founders for the fulfillment of certain specific functions. A certain need has grown up in a given community. Influential members of the community have supplied the funds and the energies sufficient to develop an institution for that particular need. They have developed this institution after years of hard struggle to a point of efficiency. They are perfectly satisfied with what they have accomplished; the need as seen by them is wholly fulfilled and the possible funds available are fully absorbed. For the Commonwealth to step in and say that such an institution shall now assume a second function, an educational function, one requiring vast changes in equipment and personnel of the staff, would so absorb the available funds and energies of the institution as to cripple it in its effort to carry on two functions and would make the carrying out of both of them inefficient. Such compulsion would force the institution in only too many instances to degenerate from one of great efficiency to one of utter inefficiency on account of the lack of interest by those in management (something having been forced upon them in which they had little or no interest), as well as on account of the division of funds which were only sufficient for carrying out the one object. In the Commonwealth of Pennsylvania no such mistaken idea is held by the state. The administrative body fully realizes the situation and believes that in the case of large numbers of hospitals not only would it be foolish for them to attempt to qualify for approval for the intern education, but it would be fatal to their interests. It is in no way necessary for any hospital so disinclined to depart from its past methods of giving service to the sick of their community; nor will it at any time be necessary so to do. There are quite a sufficient number of hospitals in the Commonwealth which are able and willing, by minor changes in administration and equipment, both

of which they can well afford and the doing of which will bring no hardship to the institution, to absorb all of the available material for internship. As a matter of fact, there are too many such institutions. The number of graduates of medical colleges are today 33 percent less than they were ten years ago. Pennsylvania has an ever-increasing number of hospitals. Consequently, the available material for internship is becoming proportionately scarcer and scarcer. Not only is this so, but large numbers of hospitals which in the past have been small, or for some reason or another have not desired the use of an intern, are now expanding and are helping to absorb the available number of young medical men for this service. The consequence of these multiple forces is that, if it were admitted for a moment that every hospital had an inherent right to an intern, there would not be the possibility of parceling out a man to each institution.

A clearer understanding of the situation will probably be obtained by a frank discussion of the whole subject; and that is what is being attempted. It is primarily the intention of the Commonwealth to secure for the intern the best possible education. From this viewpoint, its interest in the hospital is purely secondary. This is not a matter in which the interest of the intern is alone considered. If it were, the Commonwealth would have no function in the matter, as it is not concerned in class legislation. The interest the state has taken in the matter is the interest of the whole people of the Commonwealth; that each and every individual, however poor he may be, shall be assured when in the future he employs a physician that he and his family shall receive a competent service. Without the stamp of approval of the state, the citizens have no assurance of the competency of the service offered them. The effort is that the state approval shall stand as a stamp of efficiency; a minimum standard, of course, but a safe one withal. Consequently, it is perfectly proper that the Commonwealth shall say that the intern education shall consist of a certain definite line of instruction given in institutions which have definite physical and educational qualifications by means of which the standardized instruction may be given. The Commonwealth, therefore, having laid down the physical qualifications and the line of instruction, must recognize any institution within its borders which can fairly show that it is able to and does live up to the appointed standard. But the natural corollary of this is that no institution which does not furnish the standard which is demanded, both of equipment and of service of their staff, can expect to

be considered in the matter. It must, therefore, be realized that the state can have no active interest in furnishing every hospital with an intern; the fulfilling of that need, if the need exists, is peculiarly one which concerns the hospital itself, just as does the supplying itself with any other employee.

It may be truly said that the furnishing of the physical equipment, as compared with the insurance of competent instruction, is by far the easier of the two propositions. Many an institution which is physically equipped, according to the state standard, is utterly inefficient in its teaching capacity on account of the lack of proper or competent service of its medical and surgical staff. Any institution of seventy-five beds may be perfectly competent to conduct proper and comprehensive intern teaching, but a medical and surgical staff of a hospital comprising a thousand beds may utterly disqualify that institution as competent, both on account of the organization of the various services and on account of the lack of ability or willingness of the members of the medical and surgical staff themselves to take the trouble to do that which is necessary in order to bring about a systematic and proper course of instruction. The service of one or two excellent members of a staff may be totally outweighed by the indifference or incompetence of others.

Following this thought and reverting to the state's interest in any hospital, it goes without saying that the hospital which is compelled to be so organized as to teach the intern satisfactorily, is giving a maximum assurance to the community that it is offering a proper service to its patients; and the corollary to this is true, that the medical and surgical staff which is so slovenly and so careless in its duties to the intern as not to give a satisfactory service is also equally slovenly and careless in its handling of the patients.

It has been complained by hospitals that they need the services of an intern; that they have seventy-five or one hundred beds and the hospital needs an intern. They would like to have one, or possibly two, interns. This usually is the sum total in such an institution of the conception of its duties to the intern. The mere suggestion of such a proposition carries with it the knowledge that the intern in an institution of that type would not receive a proper service from the educational standpoint. What that hospital wants is an employee to do its work. What that hospital should do is to pay, in dollars and cents, the full value of the service of such an employee by obtaining a resident physician and then demanding his full time for its own services; and not to attempt to

give half of the time of the hospital and of the hospital staff to the instruction of the intern. This is the remedy at the service of any hospital which feels that it needs the service of a physician residing in the institution, and which is unable to secure interns on the merit of the service rendered and the educational advantages offered. Many hospitals imagine they are offering a fine opportunity because of the wealth of material passing through their wards, and many interns are deceived by the same token. The state conceives differently and considers the personnel and efforts of the staff far and away of the greater importance. Consequently, any hospital that cannot or does not control its staff in these matters cannot be considered as having a satisfactory service to offer in return for approval for intern teaching.

The whole question of internship and what it means has so often been misconceived that it may be of aid to hospitals to have the matter put fairly and properly before them—hence this discussion. It has been thought because of the fact, in the instance of a number of institutions whose man-

agers have discussed the matter with members of the Bureau of Medical Education and Licensure, that the results to those interested in the institutions have been so eminently satisfactory on account of the proper viewpoint having been put to them, that the discussion might be helpful to others. Quite a number of institutions eager for approval for internship, when the matter has been put before them in the above form, have wisely given up the effort to qualify and have appeared grateful for advice which has relieved them of much embarrassment, with the additional result of reorganization in points of management which has brought to their community a vastly more efficient medical and surgical service than had before obtained.

It may be said, with little fear of contradiction, that the greatest trouble with hospitals has been the lack of proper sources from which managers could derive adequate advice in regard to their various functions. The Bureau of Medical Education and Licensure stands ready at any time to assist any board of managers in regard to these matters.

FLOATING HOSPITAL OF ST. JOHN'S GUILD AGAIN AT WORK

The Specially Designed Steamer Helen C. Juilliard Ready and Serving Sick Poor Children of New York—Seaside Hospital as the Shore Institution

BY JAMES W. BECKMAN, NEW YORK

HOW THE IDEA ORIGINATED.—Forty-four years ago George F. Williams, editor of a large New York newspaper, was walking through a park one hot summer day. In those days, as now, all grassy plots were decorated with the sign, "Keep off the grass." A little barefoot newsboy, denied nature's greatest gift—the green grass, air, and sunshine of the country—was playing on the grass in the park. Just as the editor approached the boy a policeman ordered the little chap off. When he stepped on the burning pavement, his small bare feet were blistered, and he cried with pain. It was very sad. Yet the policeman was not to blame. He had done only what city laws required him to do.

EDITOR STARTS THE MOVEMENT.—The tears of the barefoot boy touched the heart of this busy editor, and he thought, "Why can't something be done for these poor little children?" Then the idea struck him to hire a boat and take the little ones of New York out in the country for a day, and let them play on the grass to their hearts' content and breathe all the fresh, pure air of the country that their little lungs could hold.

ST. JOHN'S GUILD TAKES WORK OVER.—And so

this editor chartered a barge and all the little ones who could be rounded up were regularly taken on trips. This was in 1872. The following summer the work was taken over by St. John's Guild, which has continued it to this day. The service has been greatly extended. Owing to the number of poor children, it was necessary to restrict the trips in 1887 to those who were ill and in most need of the benefit that an outing gives. Thus began the first movement of this kind for the benefit of children.

FIRST HOSPITAL SHIP MADE FROM OLD STEAMER.—The present floating hospital of St. John's Guild, the Helen C. Juilliard, is the third one which the guild has operated. The first one was made from the hull of the old steamer "River Belle," which had burned to the water line in the sound. It was renamed "Emma Abbott," in honor of the famous grand opera singer of the day, who donated the money for the boat.

The second boat was launched May 4, 1899. It was named "Helen C. Juilliard," in honor of the donor, Mrs. Augustus D. Juilliard. This boat was thought to fulfill every requirement at the time it was put in commission, but it is surpassed in

every respect by the present "Helen C. Juilliard," built with another donation from Mrs. Juilliard.

NEW BOAT IS MODEL OF ITS KIND.—The present boat has four wards, whereas the old one had only two. They are situated on the front upper deck of the vessel, where there is abundant light and air. There are rooms for operation, irrigation, instruments and bandages, and a plant for sterilizing water. There is a small mortuary in case of sudden death of any of the children. Although many of the babies which are received by the floating hospital are at death's door, it has won a reputation for saving the lives of the little ones, and it is seldom that a death has ever occurred on board, although no sick babies were ever rejected. There is a ward with three beds for mothers. A special convenience for both mothers and babies is an iron frame on the backs

CAN NOW HANDLE MORE SERIOUS CASES.—The improvements on the "Helen C. Juilliard" enable more serious cases to be cared for than was possible on the old ship because a more definite hospital angle has been carried out in the construction. The staff of this boat consists of six nurses, a superintendent, matron, and physician, with comfortable quarters for all. In the old boat there were many dark corners, but this has been remedied, as this boat sits high in the water, and there is light and air everywhere. The bed rooms for mothers and children are large and convenient. There are arrangements for various kinds of baths, fresh water, salt water, either hot or cold, and also regulated temperature baths for medicinal purposes.

SEASIDE HOSPITAL.—Seaside Hospital is situated on the shore at New Dorp, on Staten Island,



Fig. 1. Helen C. Juilliard Floating Hospital.

of the long benches on one of the decks, in which are swung little hammocks, where babies, not sick enough to go into the wards, can be placed.

The boat is a model hospital in every way. It is 215 feet over all in length, with a beam of 43 feet. It has a legal carrying capacity of 2,400, but the number has been limited to 1,200 to provide for better service.

BUILT AT COST OF \$125,000.—The ship was built and equipped at a cost of \$125,000, which was donated by Mrs. Juilliard, who died only a short while before the new ship was complete for service. Her last hours were cheered by the fact that the new boat would soon be performing its mission in relieving the sufferings of poor children. The ship is especially designed for its work, and is provided with every modern convenience. It has electric light and steam heating plants, which can be used in winter as well as summer if found necessary.

just across the Lower Bay from Sandy Hook. The salt waves wash on two sides of it, and at one corner there is only the sidewalk and the retaining wall between the hospital and the whitecaps. In front is an ideal sandy beach, with several hundred feet of shallow water, which makes it perfectly adapted for children to bathe in. The air comes off the ocean, pure, salty, and invigorating. There are five long wings to the hospital, which give it a star shape. The sides are practically all glass. The structure itself is of steel and concrete construction, but its architecture is simple and beautiful.

SCREENED PORCHES KEEP FLIES FROM BABIES.—All around the wings of the hospital are big screened porches, so that flies and mosquitoes are kept from the babies. They can be taken out on the porch and there enjoy, without molestation, the sunlight and open air of the great outdoors. The ends of the wings are big, glass-inclosed ro-

tundas, which are used as sun parlors for the little tots.

The entire plan, design, and detail of the hospital is as modern and advanced as its general architecture. From operating room, dental room, and laboratory to diet kitchen, everything is arranged in a remarkably efficient manner. The



Fig. 2. One of the wards on the Helen C. Juilliard.

hospital is exclusively for babies of the poor, but children of the rich could not secure better accommodations. Here all that nature and science can give are bestowed on the helpless little sufferers. When the child is brought to the hospital, it is taken to the waiting room, where it waits its turn to be looked over in the examining room. If it is only ill and not suffering from a contagious disease, it is registered in the register room and admitted to the hospital.

MOTHERS AND CHILDREN GIVEN BATHS.—The patients are then sent to the bath rooms to be properly bathed by the nurses. The mothers and the larger children also receive baths. Usually the mothers need the benefits of a thorough scrubbing as in the case of the children they have so sadly neglected. When mothers and children are received in the hospital, their clothing is taken from them and kept until they are discharged. The hospital provides clean, sanitary garments while they are in its care. When they leave, their old clothes are returned to them thoroughly sanitary. They are then assigned to various wards, where they are under the close observation of graduate

nurses day and night. A clinical chart and complete notes are kept on all cases, and these are preserved for statistical reference.

DOCTORS PRESCRIBE FOR EACH CASE.—At intervals a doctor makes the rounds of the wards, sees each individual case, and prescribes for it as may be necessary. The patient is kept as long as the hospital thinks it can be of benefit and no time limit is set; all depends on the child's needs and what can be done for it. If the child should be taken seriously ill, the parents are immediately notified by telephone or telegraph, and they can come at any hour, day or night; otherwise the regular visiting day is Sunday.

THOROUGH EQUIPMENT FOR OPERATIONS.—The operating cases are few, but the hospital is thoroughly equipped for any emergency. A large supply of sterilized dressings, instruments, etc.,



Fig. 3. Bath tubs for the babies and showers for the mothers on the Helen C. Juilliard.

is always on hand in case of necessity. They receive many cases which require constant dressing. When an operation is necessary, the child is anesthetized and prepared for the operation in special etherizing room. It is then brought into the operation room and placed on the table, where the operation is performed. When the operation is over, it is taken back into the recovery room, where it is allowed to come out from the anesthetic before it is taken back to the ward.

The operating room is equipped with the latest mechanical conveniences, and practically every-

thing operates mechanically—sterilizers, scrub-up basins, tables, faucets, etc. The hands are not required to operate any of the apparatus, as it is all done by foot and knee levers. The large sterilizers for the larger instruments, pans, etc., are operated by hydraulic pressure. Likewise, everything in the room in which the nurses prepare for operations works mechanically. There is almost perfect sanitation in every respect, and hence there is practically no possibility of infection.



Fig. 4. Hammocks for babies and seats for mothers on the Helen C. Juilliard.

LARGE AMOUNT OF LABORATORY AND DENTAL WORK.—Considerable laboratory work is done, for which there is a complete equipment. There is also a fully equipped dental office, in which the teeth of children are put in good repair. Caring for the children's teeth is a feature of the work; the older ones are taught and made to take proper care of their teeth, as are also mothers who remain with the children.

EXPERT DIETITIAN PREPARES FOOD FOR BABIES.—All the feedings for the babies are made in a fully equipped modern diet kitchen, with an expert dietitian in charge of all work. Every bottle is sterilized before it is used, and the supplies are kept in a refrigerating room. The cooking is done on electric plates.

In case a child should be taken with a contagious disease, there is an isolation building, in which the case can be isolated and the other children kept free from the contagion. There are abundant

toilet rooms, all fitted with the most modern installation.

HOW THE BABIES ARE BATHED.—There are elevated bath tubs in a room in which mothers are taught how to bathe their children. Not only do they bathe the child thoroughly, but they teach its mother how to care for it after leaving the hospital. There is also a large tub for the mother to take her bath after her lesson of bathing the baby. Thermostatic mixing valves automatically regulate the heat of the water in which the baby is bathed. A nurse accustomed to hot water might not be able to tell by the feel of it that it is too hot for the baby's tender skin, and all possibility of scalding a child is thus prevented.

CHILD IS PUT IN WARM CLOTHES AFTER BATH.—While the child is being bathed, clean clothes are placed in a warmer, so that it has warm garments after its bath. The child's bath room is fitted with small tubs, the little ones being bathed on a drain or bathing board and then dipped in the tub.

WHERE THE CHILDREN ARE PROCURED.—Social service workers throughout the city visit the various hospitals, milk stations, dispensaries, etc., settlement houses, tenement houses, and various other places in search of cases they think would be benefited by a stay at the Seaside Hospital. These little patients are referred to the Seaside Hospital, which sends doctors and nurses to see the cases and examine them for any signs of contagion. If none are found, the cases are accepted and brought to the hospital, where they are subjected to another more thorough examination before they are admitted. Complete records are made of all cases coming in, which continues until discharged.

TAKE THE MOTHERS, TOO.—In order to secure the sick baby for treatment, they take the mother and any of its brothers and sisters under six years of age; it is necessary to do this because the hospital is situated a long way from the homes of the children. In this way the baby is cared for and put on the road to health, while the mother is taught how to take care of the children, so that they will be healthier in the future. The whole family is put in line for new and better things.

During July and August the children are brought to the Seaside Hospital on the floating hospital. The big hospital boat leaves three piers in Brooklyn three days each week, and three piers in New York the other three days. No trips are made on Sunday.

In the months of June and July particularly the children are allowed to go in sea-bathing, weather permitting, on every day except Sunday. A guard in a bathing suit is always on hand to take care

of any emergency that might arise. There is also a nurse ready to render first aid should the occasion arise.

COMPLETE STAFF AND EQUIPMENT.—The regular staff at the Seaside Hospital consists of four physicians, a dentist, superintendent of nurses, with an assistant on day duty and another on night duty. Each ward is under the supervision of the most capable graduate nurse that can be

all do well to follow this example. Dishes are washed by a mechanical dish washer. On the inside are circulating pumps which force a soap solution over the dishes from all angles. As the dishes emerge from the washer they are sprayed with hot water and dried by evaporation.

A chute for soiled linen carries the soiled materials to a receptacle in the basement; after the clothes are laundered, they are brought up to the main store room, where they are assorted and put away to await requisitions from the various wards. Three seamstresses are constantly kept busy mending, sewing on buttons, etc. There are several store rooms for various things, such as bed clothing, etc.,



Fig. 5—The first trip on the Helen C. Juilliard.

secured. Each of the five large wards is a wing, with a large, well-screened porch on each side. The beds can be moved out on this porch, and the baby can lie or play entirely free from mosquitoes and flies. The wings are so situated that they get either the morning or afternoon sun.

CHILDREN TAUGHT IN KINDERGARTEN.—The end of each wing is a large sun parlor, in which a kindergarten school is conducted to teach the children different kinds of work.

HONOR TABLE FOR GOOD BEHAVIOR.—The patients' dining room seats 125 to 130 people. In the center is a big round table. This is the honor table, and the little ones who have distinguished themselves by specially good behavior are permitted to eat at this table. It is an honor they all prize and hope to attain. In addition to this, there is a special room in which they serve children who, for various reasons are not permitted to eat in the dining room or in the wards.

DISHES ARE WASHED MECHANICALLY.—The kitchen is situated on the top floor of the hospital instead of in the basement. Thus all the heat and odors from it float away on the breeze and none get into the hospital. Hospitals and hotels would



Fig. 6—Seasoned sailors on the Helen C. Juilliard.

and sanitary closets are at convenient corners, in which the sweepings are placed to be removed and destroyed.

THE DOCTORS' SUITE.—There is a suite of five rooms for the doctors, with sitting room and baths, and two toilets with tub and shower baths.

OFFICERS AND TRUSTEES OF ST. JOHN'S GUILD.—The most prominent and representative people of New York are in charge of St. John's Guild. The trustees and officers are all men of prominence in their respective lines, and many are nationally famous business men, financiers, physicians, and professional men.

RED TAPE REPLACED BY BUSINESS METHODS.—These men bring to the management of St. John's Guild the most efficient business methods that

American system has to offer. The result is a charitable organization without red tape, that does its work in a direct, efficient, businesslike manner. Necessity is the only requirement to secure the help of the guild. Quibble and useless

and embarrassing questions are never indulged in. St. John's Guild presents a system of businesslike management of organized charity that it would be well for other similar organizations to follow.

THE GREEN OPERATING ROOM AT ST. LUKE'S HOSPITAL, SAN FRANCISCO

Glare the Crux of the Lighting Problem—Light From Below the Source of Fatigue—Reason for the Selection of Green—Importance of a Flat Surface

By HARRY M. SHERMAN, A.M., M.D., F.A.C.S., SAN FRANCISCO.

EVER since the donors of the new St. Luke's Hospital in San Francisco built a green operating room at my suggestion and I wrote a description of it, I have been waiting for a better study of the matter of the colored operating room than I had given. This was because I knew nothing of the effect of colored walls beyond what my own experience had taught me, and it seemed to me that architects and decorators and the electric lighting men should know more, and should, taking my suggestion, be able to improve upon it and find the best possible color in general, or the best possible color for each separate place where a hospital was to be built. Therefore I sent reprints of my paper and copies of photographs of the operating room to as many technical journals and magazines as asked for them, so that the plan might have the widest publicity.

If the colored room was not discussed, I thought that someone who believed in white operating rooms would take up the question. Now, this last is what has happened, and Dr. William Lee Secor,¹ of Kerrville, Texas, has described his white operating room.

Really Dr. Secor and I are struggling with the same question, and that is the glare, and I have no doubt but that the sun can give as great a glare in Texas as it can in California. This much we have in common. To settle the question, I let into the room through *unground* glass all the light that can get there. I arrange for the reflection from white encaustic tiling of all the light that strikes the wall above the six-foot line from the floor, and the same is true of the ceiling, which is a very pale cream color. This is the light that can shine into a wound, which is where I want it. All the light that can be reflected upward from the lower part of the wall and from the floor and can then shine into the operator's face and eyes I extinguish by the dark green wainscot and floor, and I use dark blue sheets and towels and gowns for the same purpose, the blue material replacing

the original black because of its being a pleasant color instead of the absence of color. This seems to me to be a simple and economical method, for there is no waste of useful light and there is quick extinguishment of useless light.

I am obliged to believe that Dr. Secor has adopted an extravagant rather than an economical method, for he arranges to let in light "through expensive ground glass windows," and he lets in so much that the eyes must be protected from the glare from overhead as well as from below by peaked Mayo caps and by amber spectacles. This means that all in the operating room are in an overilluminated place and are subject to extra fatigue by the fact, for their skins are being bombarded from every side by light rays, and with these must go heat rays and actinic rays.

It has been recognized in industrial and commercial enterprises that physical comfort of workmen conduces to improved work with fewer spoiled articles and a larger output, and also with a minimum of accidents. Henry A. Gardner,² in the paper quoted by Dr. Secor, points this out and adds that "in some factories paints having a slightly greenish or other tint would be desirable, since a small amount of some colors may reduce the glare, but will not materially reduce the illumination." Obviously the thing to be desired is the maximal illumination with the minimal glare. Glare is an excess of light on the object looked at or in the environment, so that the retina is overexcited and fatigued. By as much as the light is in excess it overfatigues, and by as much as it overfatigues it is a disadvantage. Therefore it is that the light that can shine up from a floor or wainscot should be extinguished by tinting or coloring both floor and wainscot. Secor has quoted the article showing how little glare can come from these colored surfaces.

The selection of the color for my room was made on the basis of the complementary charac-

¹Secor, William Lee: The White Operating Room, THE MODERN HOSPITAL, September, 1917, IX, p. 170.

²Gardner, Henry A.: The Light-Reflecting Value of White and Colored Paints, with a Discussion of Their Relation to the Lighting of Factories, Schoolrooms, Public Buildings, etc., Jour. Franklin Inst., January, 1916.

ter of green to the red of the blood. Hering has shown that in pure red there is no green, and in pure green no red; that is, these colors cannot be perceived at the same time in the same color—they are mutually exclusive so far as sensation is concerned. Therefore the eye, looking back to the wound after a glance across the room, can carry none of the green impression from the floor or wainscot with it. Even if light from the floor or wainscot should be reflected into the wound, it could not illuminate it, for green light would be extinguished in a red wound.

But, even if green had not the special relation to red that it has, it still would be the first or one of the first colors to choose, because of its place in or near the middle of the spectrum. Landon and Heckel and Risley³ all agree in this—the desirability of selecting a color from the middle of the spectrum. Heckel particularly advises avoidance of the red end of the spectrum because of the “pronounced chemical changes” which the colors of that end produce in the eyes, and Landon particularly advises the selection of green, as it stimulates “capacity for work and care in the execution of it” and maintains “the vitality of the subject.” It may be that Landon’s conclusions are somewhat fanciful, even though they are drawn from a very carefully planned and executed series of experiments, or perhaps we undervalue the less obvious conclusions because the obvious ones are matters of such common knowledge, such as the depressing effect of dark rooms and the contrary effect of well-lighted ones, but his major conclusions agree wholly with those of the other two authors, who are both ophthalmologists and interested in securing in schools and hospitals restful, harmonious color in rooms, because of the effect on the eyes.

Finally, Cutting⁴ gives a reason for the selection of green in its effect upon the pupil. He shows that pupillary reactions are in accordance with luminosity, and green, blue, and violet at the less luminous end of the spectrum permit pupillary dilation, so that the eye, looking up from a red wound and seeing the blue sheets in the immediate environment and the green of the floor and wainscot beyond them, would have a larger rather than a smaller pupil when it looked back into the wound. If, on the other hand, the eye looked up from a red wound to a white environment, it would suffer at once a pupillary contraction, for the white light contains all the luminosity of the red *plus* that of all the rest of the spectrum. Look-

ing back now into the red wound, there must be a time, brief perhaps, but still measurable, when the eye must reaccommodate itself to the darker field.

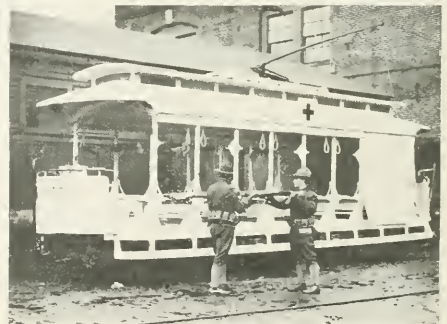
In my original plan, I tried to find a shade of green that would match the shade of hemoglobin red, and this resulted in selecting spinach green. This endeavor to get a brightness or luminosity in the green equal to that of the red was, of course, to prevent changes in the pupil. Dr. Cutting’s paper, which was presented only in March, 1917, shows that in that I failed, but that the failure was on the side of helping rather than hindering the main object of the scheme.

The surface is of importance. Obviously there must be no glaze on the green tiling or glare would be possible, and if paint is used in the place of tiling it must be a flat surface. Above the six-foot line, however, the surface should reflect all the light possible, and absorb as little as possible; there enamel paints or encaustic tilings are in order. These details have been carefully observed in the room already constructed.

Finally, all of this is to improve working conditions in the most important repair-shop in the world—the surgical operating room, where better workmanship and fewer accidents will always be needed and demanded.

Completion of First Trolley Hospital Ambulance

The first trolley hospital ambulance for transportation of wounded men from the seaports to the base hospitals has recently been completed in Boston. The ambulance was made from an obsolete open car of the type common on all surface lines. The backs of the seats were removed



Copyright Underwood & Underwood, New York.

so that the car will accommodate sixteen hospital litters and sixteen patients who are able to sit up. John Lindell, superintendent of the Boston Elevated Railroad, designed the car at the suggestion of Brig.-Gen. John A. Johnston and with the assistance of Colonel Staub.

³Rapp, Alfred C.: Surfaces and Colors for Hospitals and Schools, with Discussion by Dr. S. D. Risley. Prefatory Notes by Dr. S. D. Risley and Dr. Edward E. Heckel. Bull. 38, Educational Bureau, Paint Manufacturers' Association of the United States.

⁴Cutting, James A.: The Reaction of the Pupil to Colored Light, Jour. Nerv. and Ment. Dis., October, 1917, XLVII, No. 4.

THE STATE SANATORIUM AND THE LABOR PROBLEM

Employment of Prison Labor—Converting the Sanatorium Farm From a Liability Into an Asset—Meeting Agricultural Standards of State Board

BY STEPHEN A. DOUGLASS, M.D., OHIO STATE SANATORIUM, MOUNT VERNON, OHIO.

I HAVE been prompted to write the following because of several inquiries which I have received relative to the adoption of prison labor, the so-called "honor system," to solve some of the difficulties of the sanatorium labor problem.

The situation at this time is so acute, owing in a large measure to the exigencies of war and the consequent high price of labor, that the average institution, particularly the isolated rural institution with farm lands, finds it next to impossible to secure competent labor. This is a constant "thorn in the flesh" to the medical superintendent who is interested and is held responsible for the character of the professional work of the medical and nursing staffs, for the maintenance of discipline throughout the institution, and for the supervision of all sanitary conditions, such as the preparation and serving of food, the disposal of waste, the sterilization of infected materials, the cleanliness and fumigation of buildings, and the requisition and inspection of supplies, in addition to making a sustained effort to instruct and encourage his patients. He perhaps resents the fact that he should be held responsible for the organization and result of farm work, for which, by training and inclination, he is not particularly adapted.

The sanatorium, situated on any considerable tract of land and depending on paid labor, has on its hands today the proverbial "white elephant." A number of institutions in the Mississippi valley are so afflicted. Many state sanatoriums inherited what has proved to be the handicap of "broad acres," because building commissions had formed the habit of purchasing large tracts of land for their penal and insane institutions and no distinc-

tion was made for the institution where rest was a cardinal and fundamental principle of treatment.

This is not a dissertation or discourse on the application of graduated exercise. Only one observation is made: when a tuberculous patient is ready for farm work, or a full day of any real work, he is ready to be discharged from the sanatorium as a patient.

This institution, eight years ago, acquired 350 acres of abandoned farm land; 180 acres woodland and campus, the remainder suitable, when cleared, drained, and fenced for farm and pasture lands.

The first year some land was cleared and roads and fences were constructed in addition to some farm and garden operation. Three men were employed, but farm receipts, notwithstanding our efforts, did not balance salaries and maintenance.



Fig. 1. View of the Ohio State Sanatorium, Mount Vernon, showing in the foreground the herd of registered Guernseys which provides an adequate milk supply for the sanatorium.

In the fall of 1911, a central board, The Ohio Board of Administration, acquired control of all our state institutions. A program of general and intensive farm operation was adopted, that is, general farming, orcharding, gardening, dairying, and poultry and hog raising. An agriculturist, a horticulturist, and a veterinarian were attached to the board, who formulated and laid down uniform standards of farm organization and operation, and whose duty it was to oversee and enforce these measures. This scheme had practical application to the large penal, correctional, and insane institutions which had labor galore, but to us the proposed program, as applied to our organization, appeared not only formidable but rather ludicrous. Our "personal service" appropriation would not permit of such activity, and, if attempted, our ratio of employees to pa-

tients would become top-heavy, giving an excellent opportunity for criticism from those who believe in the "open season" for all institutions. Moreover, we knew of no similar institution carrying on such a program as evidenced by the annual reports of their farm operations. A recent superintendent's report on farm operations in a neighboring state sanatorium tersely states, "The farm shows a deficit of \$1,200."

With this formidable program staring us in the face, we appealed to the newly constituted board, explaining our difficulty and our limitations. The only solution apparent was the transfer of prison labor. In March of 1912 an "honor squad" of ten men from the penitentiary was transferred to the State Sanatorium. This was the initial transfer. The system has been applied subsequently to a number of institutions in Ohio.

to its average strength by transfers from the state reformatory.

These men are young "first offenders" having an indeterminate sentence. In our judgment, they are more efficient than the usual penitentiary transfer. We have never had any trouble among the employees or patients from the arrangement. Only a very small percentage have had to be returned because of infraction of rules, inefficiency, or insubordination. Three during the six years have taken "French leave." It is necessary, of course, that the warden exercise good judgment in selection. If care is taken, transfers for infraction of rules, etc., are minimized.

We have utilized this labor for other than actual farm work as follows: one man served in the laundry for a period of five years and after being pardoned became chief laundryman; an-

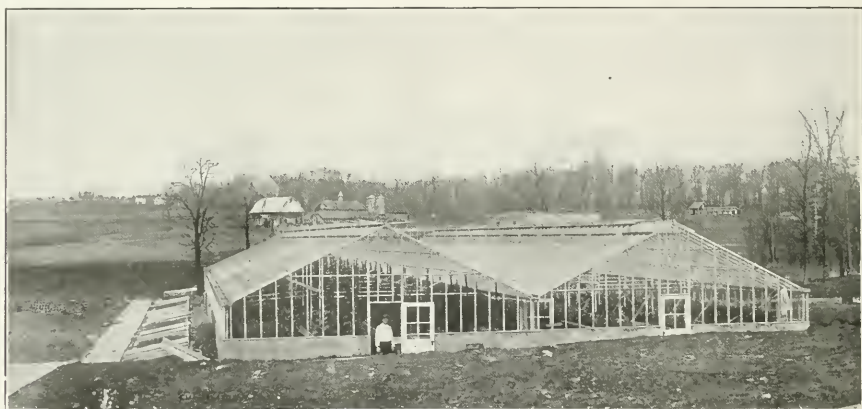


Fig. 2. The greenhouse, Ohio State Sanatorium, which was constructed entirely by prison labor during the winter months.

Dormitory accommodations were available in a wing of the power house; meals were provided at a separate table in the employees' dining room. These men, with the exception of one who was assigned to the laundry and one assigned to the chief engineer as plumber and electrician, were placed under the charge of the farm foreman and garden foreman. Two distinct departments were created, namely, farm and garden, the farm foreman being responsible for his "division of live stock," dairy, piggery, and poultry yard in addition to the farm and orchard. The garden foreman was responsible for the garden, greenhouse, small fruits, lawns, shade trees, shrubbery, and flower beds. We have had an average of eight to ten men from that time. Many have been pardoned and paroled. While stationed here, several have completed their sentence. During the last eighteen months we have been keeping the squad

other served as plumber and electrician for five years; another served in the dairy for four years; another was employed as carpenter for two years. The service of this group at \$30 a month would exceed \$6,000 for the period. Three of the group cited above were pardoned by the governor. Others have been employed as dishwashers, kitchen assistants, and lawn men for shorter periods. In the winter of 1915, we utilized this labor entirely in constructing a greenhouse.

The arrangement has enabled us to clear, fence, and drain our farm and garden lands and to cultivate them efficiently; to develop a herd of registered Guernseys, which insures an adequate milk supply; to set out and cultivate an orchard and vineyard; to operate a greenhouse, which supplies us with fresh vegetables and flowers during the winter months; to maintain a piggery and poultry plant at a profit, and to care for our campus and

grounds. Transportation of supplies from the station three miles away is handled without difficulty.

The selection of the foremen is important. The qualifications of these men should be investigated carefully and sufficient salaries should be paid to acquire and hold suitable talent. One man can control and develop among this class of labor an *esprit de corps* which will make them efficient and trustworthy; another fails signally. We had one man who failed because he assigned and divided his work instead of "bunching" his men and setting the pace for them. In other words, he attempted to become a supervisor instead of a working foreman, and the system broke down.

Under this system the sanatorium farm has finally become an asset. Receipts have shown a gradual annual increase, and we believe we are making a creditable showing. Our acreage production compares favorably with that of any other institution. Increased farm and garden receipts have, to a considerable degree, enabled us to keep pace with the "H. C. L." and to keep within reasonable bounds the ever-increasing tendency of the per capita cost. Receipts over cost of production for the year amounted to \$8,000. Prices of produce were based on a uniform schedule prepared by the board, which is 8 to 10 percent under prevailing prices.

Labor credit, other than actual farm work, balanced salaries and wages. All expenses against the farm and garden, including maintenance of these men, interest on investment, depreciation in equipment, etc., have been carefully computed and charged. The farm and garden show a net 35 percent profit on the gross receipts based on the accounting system as set forth in Bulletin 511, U. S. Department of Agriculture.

The system allows more liberty, better environment, better diet, and a happier, healthier, existence for these men. We believe the system warrants adoption by all state sanatoriums with the "broad acre" impediment, for in no other way could we have made a semblance of a showing or have had a solution of the problem, nor could we have escaped criticisms for our failure to fulfill the "agricultural standards" of our board.

A French girl of sixteen wrote to a war worker in Washington: "There is a river in France so narrow that you can talk across it, birds can fly across with one sweep of their wings. There are great armies on either bank. They are as far apart as stars in the sky—as right and wrong. There is a great ocean—it is so wide that the seagulls cannot fly across without resting. Upon either shore there are great nations. They are so close together, however, that their hearts touch."

AN AMERICAN RED CROSS HOSPITAL IN LONDON

Inviting and Luxurious Appointments of Latest Hospital for American Officers

The American Red Cross Hospital No. 24, which was recently opened at 24 Kensington Palace Gardens, W., may be summed up in one word—"perfection," according to a writer in the *British Journal of Nursing*. The house, its equipment, and running expenses are the munificent gift of Mr. Chester Beatty. It was offered to the American Red Cross Society for the use of American officers, should the authorities decide to bring them to England instead of nursing them in France, as it is at present proposed. In the meantime, British and Colonial officers are to be received. It has thirty-five beds and is staffed by the American Red Cross, under the commanding officer, Captain Chollett. The Nursing Staff consists of a matron, four sisters, and V. A. D. probationers. The matron, Miss Minnette J. Hay, was trained at the Roosevelt Hospital, New York.

On the ground floor of the hospital are the library and lounge, both ideal for their purpose. The lounge is upholstered in soft green and has a plentitude of luxurious easy chairs. It opens into the fine conservatory, from whence the patients can be wheeled into the quiet, high-walled garden.

Every ward is charming, with its white enameled furniture and white piqué quilts, the silken eiderdowns and curtains giving various color tones in the different wards. Some are soft rose color, some blue, and some old gold. The buff screens which prevail in most of the wards are particularly restful. The white bed tables and enamel lockers with glass tops are the last word in appearance and utility.

The luxuriously appointed bathrooms, of which there are a large number, will be a joy both to the patients and their nurses. Indeed, it would be difficult to suggest anything for use or ornament that has not found its place in this ideal refuge, which is ready and waiting to receive the sorely pressed, weary, and wounded officers who are making such a magnificent stand at the front. Nothing has been spared that will minister to their healing and recovery.

Industrial War Gardens

The Inspiration Consolidated Copper Company, of Arizona, has given an excellent example to other great corporations in fostering the Victory garden among its employees.

"At present there are over 500 war gardens planted in this district, and by the end of the month there will be 800," writes J. R. Sandige, agricultural expert with the company in Gila County.

The Inspiration Company cleared, fenced, harrowed, ditched, and leveled 75 acres of soil, divided it into eight-acre tracts, and furnished the seed and water to any employees who would undertake to raise the crops. All the gardener is expected to furnish is hoe and "pep." Instructions are furnished by Mr. Sandige and his assistants.

A Victory garden market has been established in connection with this work, and this year a community canning and drying plant will be installed, with the water and fuel furnished free. What this company is doing other corporations could do, and there is still time to act.

There are two things I never worry about—those things I can't help and those I can.—Robley D. Evans.

HOSPITAL ACCOUNTING

Complete System of Bookkeeping for Either Large or Small Hospitals and Allied Institutions—Methods for Purchasing, Receiving, Storing, and Distributing Supplies—Forms for Record Cards, Blanks, and Books to Be Used for the Systematic Management of the Hospital—Practical Budget System Presented

BY CHARLES A. PORTER AND HERBERT K. CARTER, OF THE STAFF OF THE MODERN HOSPITAL.

INTRODUCTION

THE authors of this series of articles fully appreciate the difficulty of devising a system of accounting that will meet the requirements of all hospitals. Local conditions in different hospitals, regardless of the sizes of the institutions, will always vary. A one-hundred-bed hospital located in New York may have an entirely different organization from one of the same size in another city or one of the same size in the same city. In fact, it is seldom that any two hospital organizations will be found that are alike in every respect. It is this difference in organization which makes it impossible to devise a method of accounting suitable for all hospitals.

On the other hand, the same underlying principles govern the accounts of all hospitals—the theory of debit and credit is the same the world over. This fact has given us hope that these articles will be a help to the hospital administrators.

All hospitals should have a complete accounting system, with internal checks, that will show all revenue and expenditure, and give comparative statistical data that will be valuable to the management from year to year and to those interested in hospital work throughout the country.

The methods described were formulated after a thorough study of the accounting systems used in many of our leading institutions, and designed to meet their needs with regard to detailed information for the Superintendent and other hospital executives. We do not claim that every institution can advantageously install the system as outlined without changes and modifications to meet particular needs.

In presenting these articles we assume that those in charge of the records pertaining to the business transactions of a hospital are experienced in accounting practice, and will be able to distinguish between those methods which they can adapt to their own use and those which they cannot use to advantage.

We have gone further than the bare theory of accounting as set forth by the text-books on the subject, and have outlined a purchase order system, showing forms of orders, price cards, and

other records, and the manner in which they are to be handled. A receiving and storage system, showing how the supplies should be kept, distributed, inventoried, and their controlling accounts kept in the general books, is given in detail. We have also shown how a departmental expense analysis should be made up and how the budget should be prepared for presentation to the Board of Managers.

It is by analyzing expenses that we are enabled to inaugurate savings. Comparisons are the friend of the Superintendent, because, by showing where curtailments may be made, they enable him to get the best results with the money at his disposal. An important point to be remembered is that the best method of showing the variations in the financial standing of an institution is by means of a properly designed chart.

Simple forms of single and double entry bookkeeping will be given, with the rules which govern all bookkeeping.

The various forms mentioned by number in the text will be found printed in the installment having reference to certain forms, and the reader, by studying these forms in connection with the text, will obtain a more comprehensive idea of the system outlined.

We wish to thank those hospital executives who have so kindly assisted us in the preparation of this matter, both for the courtesy they have shown us and the valuable suggestions that they have made.

CHARLES A. PORTER.
HERBERT K. CARTER.

ACCOUNTING SYSTEM

PURCHASING

One person known as the Purchasing Agent, though he may have other duties, should have charge of purchasing all supplies, materials, and equipment for the hospital. The Storekeeper and Receiving Clerk, whether the two positions are held by one man or more, should make reports to this person of the receipts of purchased commodities.

The records of the Purchasing Agent are duplicates of orders, price cards, contracts for the pur-

the Purchasing Agent's files, and the triplicate going to the Receiving Clerk. The Receiving Clerk is thus notified as to what goods he is to expect and from whom. This triplicate should not show quantities of goods ordered, the Receiving Clerk being required to make an actual count of all goods received.

Form 1. Price Card. Actual size, 6 by 4 inches.

Form 1A. Reverse side of Price Card.

Supplies are those articles, purchased for consumption or maintenance, which cannot be charged to the equipment or material accounts.

Form 2. Detail Price Card. Actual size, 10 by 8 inches.

Form 2A. Reverse side of Detail Price Card.

Equipment embraces furnishings, apparatus, instruments, etc., necessary for the operation of a hospital; as a rule, to remain in use for more than one year.

[illegible]

The use of price cards (Forms 1, 1A, 2, 2A) is recommended. They should give a complete description of all of the ordinary supplies used in the institution. This information includes price, quality, size, brand, etc., the names of firms making quotations, and the dates of the quotations.

ORDER REQUISITION

Superintendent _____ Date _____

To the _____

FROM _____

RELOCATION _____

DATE _____

STATED _____

ORDER NO. _____

Requested by _____ Approved _____ Superintendent _____

Remarks _____

Contracts may be made either on standard forms or by letter. They should be made for coal, showing size, percentage of ash, British thermal unit per pound, and other details—prices, terms, and deliveries; for milk and cream, showing percentage of butter fat required in each grade and

Month Ending _____ 191_____

[illegible][illegible]

No.	
DRUG REQUISITION	
Dept _____	
Date _____ / ____ / ____	

By _____ Head
Approved _____ Supt of Nurses

Dept. _____ No. _____

Requisition for Repairs

Date— 191 Location

REPAIRS REQUESTED

Signed

Approved and assigned to

Signed _____ Ass't Sup't

I certify that the above repairs have been made

Signed - - - - - Dep't Head

N B Mechanic will have above requisition signed by Head of Department requesting repairs, and return the order to the office of the Superintendent.

be enabled to locate those desired without undue trouble.

In the large hospitals having all the clerical help needed a complete card record of prices should be kept, showing cost per pound, ounce, brand, cubic centimeter, or in grains, so that a monthly report showing the number and cost of all prescriptions compounded for each department can be made out.

Supplies should be issued only on requisitions. All requisitions should be made out by the head of

the department, and approved by the Superintendent, except in the case of the Steward's supplies. Requisitions from the Steward should go direct to the Storekeeper.

Four forms of requisitions are shown—namely, order requisition (Form 4), supply requisition (Form 8), drug requisition (Form 9), repairs requisition (Form 10).

A requisition containing a printed list of the main articles required by the Steward and Housekeeper is sometimes used in large hospitals.

DISTRIBUTION OF STORE SHEET

The correct manner in which to handle charges for supplies is by means of the store distribution sheet (Form 7). All requisitions for supplies are totaled daily for each department, and the amount entered on the sheet under the department heading. At the end of the month the columns are totaled and charges made to the various departments on the general books. This necessitates an account captioned "Supplies," and is handled through the Charge Register just the same as the material account.

This method enables the hospitals to charge off supplies as used instead of as purchased, which is common custom.

The value of supplies as shown by the general books should equal the value shown by the stock cards.

INSTRUCTIONS FOR ORDERING SUPPLIES

1. Do not tear out the original copy.
2. Do not write in the column headed "Issued."
3. Do not crowd orders for more than one article or form on one line of the sheet, but use a second sheet if necessary.
4. Do not fail to insert quantity on hand in proper column.
5. The column headed "Issued" will show just what has been supplied on the requisition, and when the space has been left blank it means goods ordered will follow as soon as possible.
6. Give as good a description as possible, especially as to size or number.
7. Articles of equipment will not be furnished or replaced until others have been condemned in the usual course.
8. When condemned goods are returned to the store room, a list must accompany them and be marked "Condemned Goods."
9. Order all blank forms by number, and not by the description or heading. All forms are numbered.
10. On receipt of goods, quantities should be checked and Storekeeper notified at once of errors.

11. Requisitions should be limited to a supply sufficient for one week.

12. The storekeeper will not issue goods without a signed requisition approved by the Superintendent.

DOUBLE ENTRY BOOKKEEPING

Owing to the complex transactions involved in the business of hospitals and allied institutions, double entry bookkeeping is the best method of recording them. The three principal reasons for this are: first, because of the element of time which enters into the transactions; second, because there are internal and external checks which guard against error and help to prevent fraud; and third, to obtain proper statements of the operating cost and standing of the organization in minute detail for comparative and statistical purposes.

These statements can best be obtained from a double entry system, which shows a complete record of every transaction on both the debit and credit sides of the various accounts. An account is kept with every element of the business, such as personal accounts, supplies, capital, real estate, cash, loans, mortgages, etc.

In hospital accounting it will be necessary to keep the following books: Journal, Cash Book, Charge Register, Pay Roll, Check Book, Pay Patients' Ledger, and General Ledger.

For statistical information, other books and reports, to be described later, are kept.

The Journal takes care of all entries which cannot be properly entered in the Cash Book or Charge Register. These entries usually require a brief description.

The Cash Book takes care of all transactions involving cash, and the Charge Register of all bills payable.

The Charge Register becomes the foundation of statistical information, as it shows the distribution of all expenditures. A notation is made in this book when bills are paid, which furnishes a means of obtaining a list of creditors.

The total of bills payable of previous months as shown by the ledger, plus the total of debts incurred for the month, less those paid, gives the amount of bills remaining unpaid at the end of the month.

A comparatively new kind of Cash Expenditures Book called the Combination Cash and Check Book (Form 19, which will be shown in the next installment) is recommended. This takes the place of the Cash Expenditures Book and the Check Book. This method of handling disbursements is being adopted by many institutions and saves considerable time. It gives an exact dupli-

cate of all checks and reduces the possibility of fraud or error by eliminating the necessity of copying.

Ledger accounts are opened with people, property, funds, stocks, bonds, mortgages, loans, cash, material, supplies, interest, bills receivable, bills payable, equipment, real estate, and others as may be necessary.

The accuracy of all these accounts is tested by listing all of the debits and credits of the General Ledger, totaling them and then noting whether the totals agree. If it should happen that these two totals do not agree, it is positive evidence that there is an internal error or that some fraud has been perpetrated.

All entries in books of original entry are posted direct to their respective accounts in the General Ledger.

A few of the general rules of double entry book-keeping are given below:

1. For every debit there must be an equal credit.
2. Debit all receipts.
3. Debit that which costs value.
4. Credit all disbursements.
5. Credit that which produces value.
6. Debit interest for its costs.
7. Credit interest for its returns.

In many institutions all of the books are kept in one office by one accountant. In an institution of this kind the following books will be necessary:

1. Journal.
2. Charge Register.
3. Accounts Receivable Ledger.
4. Pay Roll.
5. Stock Cards or Ledger.
6. Cash Receipts.
7. Cash Expenditures.
8. General Ledger.
9. Trial Balance.

In most hospitals it is necessary to keep a set of books known as the Superintendent's and another known as the Treasurer's. In this case the Superintendent's books are:

1. Journal.
2. Charge Register.
3. Pay Patients' Ledger.
4. Cash Receipts.
5. Cash Expenditures.
6. Stock Record.
7. Pay Roll.
8. General Ledger.
9. Trial Balance.

The Treasurer's books are:

1. Journal.
2. Cash Book.
3. Income Ledger.

4. Endowed Bed Ledger.
5. General Ledger.
6. Loans Book.
7. Trial Balance.

Into these the Treasurer incorporates the report of the Superintendent to him and the fund and capital entries to be found in his own books of original entry.

(To be continued.)

CENTRALIZED PURCHASING AS AN AID TO HOSPITAL ECONOMY

Cleveland Hospital Council Establishes a Purchasing Bureau, Affiliated With New York Bureau

The purchasing bureau of the Cleveland Hospital Council began operation on June 15. Mr. Guy J. Clark, former assistant purchasing agent for the city of Cleveland, has been employed as purchasing agent for the council.

Centralized purchasing has been under consideration by the Cleveland Hospital Council for over a year. In the spring of 1918 the executive committee recommended that the council organize a purchasing bureau; that the council affiliate with the New York Bureau of Standards and Supplies; and that the Welfare Federation be requested to assume responsibility for the raising of funds required for this department.

In discussing the proposition that the council organize a purchasing bureau, the committee on purchasing and standards said:

"The twenty hospitals now represented in the council do their own individual purchasing of provisions, general supplies, medical and surgical supplies, etc., amounting to approximately a million dollars a year. A central bureau, properly organized, would be of real service to the hospitals in this work. While it is difficult to estimate savings in advance and at all times difficult to determine the results of centralized purchasing in dollars and cents, undoubtedly considerable saving could be effected in the joint anticipation of wants and the purchasing of bulk and standard articles. It could be helpful in the formulation of contracts and putting hospitals in touch with the proper places to buy commodities. It should be a bureau of information to be consulted by the hospitals at any time on all matters involving purchasing and standards. Experience in modern business has proved conclusively that centralized purchasing is worth while. There is no reason why such business principles cannot be effectively adapted to hospital management throughout a common purchasing bureau. The hospital council and its constituent members are ready for such a bureau. The services of the bureau might soon be available to the various children's institutions, all of which purchase supplies such as are used by hospitals. In time, the principles of centralized purchasing as applied to these institutions might be extended to all of the various welfare institutions in the city."

The Chemical Corps

They get no song to boost 'em along, they get no words of cheer;
For what they do is a job so new some of us don't know they're here;
But they work away in the lab all day to help us win the war;
Let's not forget we owe a debt to the men of the Chemical Corps.

For it's HCl to give 'em hell, and H₂SO₄.
C₂O₃ and TNT—the men of the Chemical Corps!

—F. P. A., Stars and Stripes.

LITTLE JOURNEYS TO PLACES AND PEOPLE WORTH KNOWING

The Third Little Journey—To St. Anthony's Hospital at Carroll, Iowa—A Hospital Which Has Much Picturesque Beauty of Surroundings and a Great Community Value for a Large Rural Population

By MARGARET J. ROBINSON, R.N., FIELD EDITOR OF THE MODERN HOSPITAL, CHICAGO.

THE town of Carroll, Iowa, is small and not particularly inviting at first glance. There is, of course, a railroad station. There has to be a place for the train to stop, and a waiting room, and somewhere to check baggage, and some place to house the spittoons and the penny-in-the-slot machines from which you can get a minute portion of chocolate or chewing gum when they are in working order. Then there is a main street; there are some stores and a courthouse, a moving picture show, a restaurant, and quite a lot of houses, and last but far from the least, a hospital.

I must confess that my hopes did not rise very

hood that owns it, whose mother-house is at La Crosse, Wis., bears the quaint and stately name of "Franciscan Sisters of Perpetual Adoration."

The community owns forty acres of land and has its church and grade schools, a high school, a new building for the school of domestic science, farm lands and outbuildings, and the Hospital of St. Anthony.

St. Anthony's crowns a hill and overlooks a clear stretch of winding creek and rolling hills beyond. On the left were plowed fields and orchards. You have to go around the half circle of the building to reach the front door. The archi-



Fig. 1. A birdseye view of the buildings of the community of the Sisters of St. Francis of the Perpetual Adoration.

high as to what that hospital might be like when I found it, but I certainly had a most agreeable disappointment in this particular case. Carroll at first gave nothing to show that in this little county seat was to be found one of the best hospitals in the state—a hospital filling a great community need, and one that has picturesque beauty and a very human atmosphere about it. Which all goes to show that sometimes we find the biggest and finest things in little places, and that the greater credit is due to those who make progress where progress is most needed and sometimes the least expected.

The community of which St. Anthony's is a part is about a mile outside of the town, and uphill toward the last of your journey. The sister-

tect was wise enough to face the hospital toward the hills and the creek in the valley instead of toward the road leading to the town. Entering the hospital, I was greeted as an expected guest, for some time previously I had met two of the sisterhood in Des Moines and told them that I was coming to Carroll later.

Sister Antoinette, the superior, came to show me the courtesy of the house. Sister Antoinette and all the other sisters are proud of St. Anthony's, and well they may be proud of this delightful place of rest and comfort for the sick, where one can get food from the garden and the cows and the chickens straight to one's bedside tray, find means for scientific diagnosis, and get good nursing care and a human interest in the

individual. What more could any poor sick man or woman ask from a hospital than this?

The superior and the sisters in charge are enthusiastic hospital workers. They are not content with any equipment or methods they have used if they can learn of any better. They are planning to build an isolation hospital for infectious diseases and a twenty-five-thousand-dollar building for a nurses' home on the campus. The plans for this home will include a basement which is to be used entirely for a gymnasium and indoor sport. The first floor will have parlors and din-

I don't wonder that they want visitors to go to that roof. The clear and unobstructed view of God's country you get from up there is an inspiration. There is nothing between you and the sides of the sky but rolling land and creek and cultivated farms as far as your eyes can see. It would be worth climbing the stairs to see if the elevator were out of order.

The sister superior waved her hand to the right and left and said, "You see we have here almost everything we need to eat. We raise it ourselves, and, in the summer, the fresh things we do not



Fig. 2. One view of St. Anthony's Hospital.

ing rooms and offices which will be used for a graduate nurses' registry.

This graduate registry will be a unique thing for a rural district. Any graduate, whether of this school or any other, may register here and have her room and make this nurses' home her home. Each nurse, whether graduate or pupil in training, will have a room to herself, and each of these rooms will have a lavatory with running hot and cold water.

After telling me of the plans for new things, Sister Antoinette said to me, "I am going to take you to the roof and show you the view from there, and then we can come down and see everything on our way."

eat we put up for the winter. There are our cows. We have always fresh milk and butter, and over there are several hundred chickens, and we have chickens and eggs from our own back yard. We have two or three farmers to look after it for us. The high cost of living and running a hospital does not bother us as it does the people in the cities."

Then we came down to the top floor of the building. Here, high above the hospital atmosphere, in a separate wing, are the nurses' quarters, cozy and comfortable and homelike.

The next floor of the main building has well-equipped and busy operating rooms and a separate wing for the obstetrical department. This

wing has a maternity room and nursery and pleasant rooms for the obstetrical patients. A graduate nurse is in charge here.

I asked Sister Antoinette if it was not hard to get the country people to see the need for hospital service in maternity cases, and she said, "Oh, yes, it was at first. I remember one grandmother who boasted that she had had eleven children and never even had a doctor with one of them. She

four patients in the hospital, but now they come from fifty miles around, and two years ago we had to build again to make room for them."

On the next floor below are private rooms and some two-bed rooms. There are no wards. The country people do not want to go into them, and the sisters do not believe in them. There are sunporches at the end of each corridor, and these are arranged to take care of out-door cases when this is necessary. The out-door patients thrive in the breezes that come over the hills.

Opening the door of a utility closet, where the brooms and mops and pails are kept, Sister Antoinette showed me the zinc-lined dust chute, which goes down through the building. It can be filled with a suction air current from below by turning on a switch at the side of the chute. Dust and floor refuse are carried by the current below to the incinerator, and dry floor mops shaken out in this chute have the accumulated dust and rolls of lint drawn out of them.

Each corridor has its diet kitchen, and all were spotless. The trays were not elaborate but were immaculately clean. The silver and china shone, and the tray cloths were of shiny white hand-ironed damask with a little crocheted edge around them. It is still a mystery to me how these diet kitchens are kept so clean. The sisters must have a magic lamp somewhere, and when the meals are over they probably rub it and say "Little table, disappear," and then all the dishes wash themselves and fly to their proper places in the cupboard.

Down on the first floor, which is much like the others, is a special operating room with an unusually good modern equipment. The artificial lighting of this room comes from a large central cluster of blue-globed nitrogen lights. When this is turned on in the darkened room it fills the room with a clear artificial daylight that is startling and reminds one of a stage effect. These lights were especially planned and designed for this room, and have given very satisfactory service.



Fig. 3. The pathologist's assistant at her work.

had a daughter who was brought alive through an abnormal and serious case here and her baby too. Now the grandmother announces with pride that no daughter of hers shall stay at home for confinement. That is the way it is. When they understand the protection the hospital can give them, they are glad to come.

"When I first came here, six years ago," Sister Antoinette continued, "there were only three or

On the first floor also is the case record room. One of the graduate sisters is in charge of this room and is responsible for all of the case records. These are very complete, including preoperative diagnosis, physical, pathological, and radiographic findings, history of treatment and operative procedure and summaries—in fact all the



Fig. 4. A sturdy new farmer who started life at St. Anthony's.

things that Dr. Codman says go to make a case record. The files at St. Anthony's show "what was the matter with the patient, what the doctor did for him, and what the result was."

We went down into the basement and saw the nurses' demonstration room, the sewing rooms, the living rooms and the rest room for the help, and the hydrotherapy rooms, and then came to the radiographic laboratories. There was an up-to-date machine with all the accessories needed to do detailed stomach and intestinal work. The sister in charge is well trained and does thorough work. She showed us series of bismuth-meal plates, clearly outlined and developed, and "before and after" bone plates of cases in which good arms and legs and hips had been made of bone injuries which looked in the first plates like indistinguishable messes.

The pathological laboratory is supplied with every means to detect any bugs that intrude themselves into your anatomy. Just outside of the laboratory there is an animal house for the rats and guinea-pigs. The salaried pathologist is a woman physician who has had a long and thorough training in her special work.

"And now," said Sister Antoinette, "we will show you what we have to eat."

We went down the hall, and taking a bunch of keys from her girdle, she opened up the store-rooms. Here, too, there must be a genie of the lamp. The shelves were full of home-put-up fruits and vegetables in shining clean glass jars. I didn't see a tin can anywhere. The food that comes to the trays at St. Anthony's never gets any personal acquaintance with railroads or cold storage plants or packing houses, and I am afraid that the retail grocers would have little business if they depended on the kitchens like St. Anthony's for trade.

As we passed through the main kitchens, one of the sisters and one of the cooks were fixing big pans of fresh-picked dandelion greens, and there was soup cooking on the stove that smelled like the kind they make at home.

We went next to the cooling room. This is chilled by a cold-blast fan refrigerating system.



Fig. 5. Getting ready for a bath in the sun.

There wasn't any characteristic ice-box odor about the place. Dishes of food and trays full of little pats of fresh butter ready for supper lay on the shelves, and everything here was spotless, too.

After showing me the whole of St. Anthony's, Sister Antoinette took me through the grounds over to the domestic science building. In the garden we passed a shrine where a meek Christ, a red lamp burning at his feet, stood in a niche made of shrubbery just turning green.

In the school of domestic science they are teach-

ing girls how to cook and to make their own clothes and to do beautiful laundry work. Down in one of the demonstration diet-kitchens, sitting among a friendly group of sisters, we talked of plans to affiliate the dietetic department with the hospital, and of how St. Anthony's could give even better service to its patients and how domestic science pupils could get better training, when the special diets for patients in the hospital would

be made in the kitchens of the domestic science school.

And so ended my visit to St. Anthony's, and this is the memory I brought away with me. When Sister Antoinette had showed me the sisters' rest room, where they come for meditation and prayer, she said, "But we don't get much time to pray here. We must pray while we work." And that is the spirit of St. Anthony's.

FROM THE FIELD EDITORS' NOTE BOOKS

A Hospital That Is a Community Educational Center—A Creditable New Hospital Building—Nerve Conservation in the Training School—A Serviceable Chart Rack

Cottage Hospital, Creston, Iowa

There are cities of twenty to thirty thousand population in Iowa that have not begun to do the public health work that the little town of Creston, with less than five thousand people in it, is doing for the hundred thousand people of the farming country around it, and when the Cottage Hospital is completed and in running order, it will compare favorably with the hospitals in the two or three large cities of the state.

This hospital is equipped with everything to make scientific diagnosis. It will have a clinical out-patient

and equipment is concerned, this hospital will have no handicap in its efforts to do good work for the city of Waterloo.

St. Joseph's Hospital, Ottumwa, Iowa

St. Joseph's Hospital in Ottumwa, Iowa, has a rule of the training school, that after the nurses have eaten their midday meal, they must sit down for fifteen minutes in the living room, and listen to the Victrola or read or knit or whatever else they choose to do. This surely is nerve conservation, and every nurse goes back to her work more cheerful and rested than if she had rushed from the table to her work again.



Proposed greater community center or home for a sustained life and health conserving service in Central Southwest Iowa.

department and social service. It will be a community educational health center, and provision is made for public health lectures and instruction, Red Cross first-aid classes and public clinics. The hospital has a complete record system of its cases, and has files that show complete diagnosis and treatment and the results obtained.

Dr. C. E. Sampson is the moving spirit of the Cottage Hospital and its public health activities, and the work in Creston has reached its present success through the force of his energy and personality and through the progressive men of his profession who have gathered around him.

St. Francis Hospital, Waterloo, Iowa

St. Francis Hospital, Waterloo, has a new building of the best type of steel and cement construction. The interior shows the same type of building materials, and only the best of flooring, walls, and furniture have been used in the new buildings.

There is the most modern equipment in the operating rooms and service rooms and kitchens. As far as building

Chart Rack



The chart rack shown here was described on page 29 of the July issue. It was designed by the sister superior of the Sacred Heart Hospital, Fort Madison, Iowa, where it is in use.

We are not sent into this world to do anything into which we can not put our hearts. We have certain work to do for our bread and that is to be done strenuously; other work to do for our delight and that is to be done heartily; neither is to be done by halves or shifts, but with a will; and what is not worth this effort is not to be done at all.—John Ruskin.

THE CONDUCT OF HOSPITALS

Who is to Be Given the First Consideration? The Patient
—Importance of Site, Plans, and Provision for
Comfort and Safety of Patient

BY R. W. CORWIN, M.D., Chief Surgeon, Colorado Fuel and Iron Company, Pueblo, Colo.

In 1881 the following notice was posted in Minnequa Hospital: "Who is to be considered first in this hospital? The Patient."

In the conduct of hospitals the first consideration should be given the patient. Let it be understood from the beginning that a hospital, whether private, semiprivate, general, special, emergency, or war, is for the benefit of the patients, and not for the convenience of the doctor, intern, medical student, or nurse.

The second consideration should be given to the site. I feel that no hospital, except an emergency hospital, should be located in a city, where it is dusty, dirty, and noisy; that a hospital should be located where there is plenty of room for grass, flowers, shade trees, and opportunity for outdoor life. If a hospital be of benefit to a medical school, its doctors and students, let the school go to the hospital instead of the reverse; consider patients first.

The third consideration should be given to plans of hospital buildings. If the hospital be located to best advantage, it has been found that buildings of one or two stories have advantages over those of many stories. Construction is less expensive and, for service given, more economical to maintain. Plans should call for fireproof construction and elimination of the elevator, which is noisy, expensive, and, in case of fire, dangerous. Inclines graded 1 foot in 6 meet every demand of elevator or stairs. They accommodate every class of ambulatory patients—old or young, stout, weak or crippled—are convenient for moving wheel chairs, stretchers or beds, and, in case of fire, safest. In place of elaborate front and entrance, expensive board meeting room and showy corridors, let the wards and lower-priced rooms be better furnished and decorated. Cork carpet, varnished, or painted and varnished, has proved durable, noiseless, not slippery or cold, and comparatively easily cleaned. If cleanliness of operating room floor and walls be deemed essential, let sheet lead be considered for floor and wall covering; it is durable and withstands the direct application of live steam.

The fourth consideration should be given to the comfort and safety of the patient. Dirt, noise and odors should be eliminated as far as possible. Sterilization should be considered, not in connection with an operating room only, but as well with the culinary department. Preparations against infection in the operating room are thorough; in the kitchen, sadly neglected. More attention should be given to the cleanliness—sterilization, if you please—of food, cooking utensils, tableware (knives, forks, spoons, plates, cups, glasses, etc.), of table linen and dish towels, of cooks', waitresses', and help's clothing and hands. The elimination of carpets, large rugs, window roller shades, and decorative drapery in rooms and wards is desirable. Ventilation in addition to the indirect, forced draft, or fan—inexpensive and of decided benefit to the patient and comfort to nurse—may be obtained by providing an inside awning, fastened to the window and dropped at will over the head of the bed and patient, leaving the body in a warm room. If properly arranged, the patient has the benefit of outdoor air and is protected from draft and storm. Loud talking or laughing by doctors, nurses, visitors, or patients should be prohibited. Noise from

slamming doors, dropping things, or swishing of over-starched skirts can be and should be minimized. Odors from medicines, drugs, or chemicals that are useless or not essential—i. e., iodoform, lysol, etc.—or from general or diet kitchens, or from lack of ventilation, are inexcusable. Smoking in a hospital (except in a room especially prepared and that the farther away the better) should be peremptorily forbidden. Any person who smokes in a hospital or enters a sick room with tobacco smoke, fresh or stale, in his clothes or on his breath, should be forbidden the privileges of the institution.

Better team work, better laboratory work, better case work, more scientific medical and surgical work, more authority given to the superintendent, one head—and eternal vigilance—these are the watchwords.

Patiently we await the detailed report of the Standardization Committee, but in the meantime and all the time, remember and never forget, first to be considered is the comfort, safety, and welfare of the patient.

NURSING SIX MILES FROM THE GERMAN LINES

La Panne, in Free Belgium, Site of An Interesting War Hospital—Scientific Character of Work Done

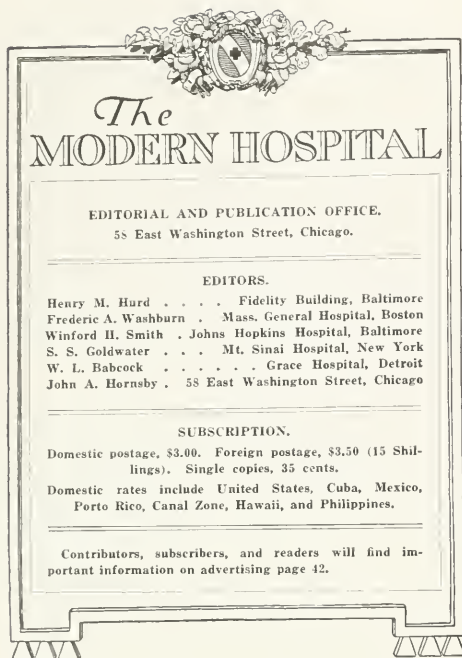
One of the most interesting of war hospitals is the Hôpital de l'Océan at La Panne, planted on the little strip of Belgian soil undesecrated by the foot of the invader, and only six miles from the German lines. Not only a hospital, but a university, with a cosmopolitan staff—the nursing staff including English, Scotch, and Irish, French, Belgian, and Canadian nurses—the work under the control of Dr. Depage, with Miss Violetta Thurstan as matron, is of a very fine order.

As an instance of the scientific character of the work, it may be mentioned that, in the case of wounds, a "microbe chart" is kept, in addition to those with which every nurse is familiar. If the chart does not show a regular diminution, the reason why is thoroughly investigated. The result is that the majority of wounds speedily become microbe-free; they are then sutured and treated as aseptic wounds.

The nurses have their own club, maintained by a small subscription from each member. Formerly an ordinary wayside inn, it stands close to the Plage, over which sweep the health-giving winds from the North Sea. It is a center of social life, and its activities include gymnasium classes, an arts club, and concerts. There is also a very useful mortuary society, to which forty people—doctors, nurses, and orderlies—belong. Each pays 50 centimes a month, and the little chapel has been adequately equipped and is reverently cared for by the members.

It is difficult to realize that all this well-organized professional and social life goes on within range of the German guns. The protection of the hospital is that the enemy has also a hospital some six miles from the frontier, and they have received notice that any attack on the Hôpital de l'Océan would at once mean reprisals. So, though shells whistle overhead, the hospital has been safe, and, with its *avant poste* close to the frontier, carries on its invaluable work.—Canadian Nurse and Hospital Review.

I hold every man a debtor to his profession; from the which a man of course do seek to receive countenance and profit, so ought they of duty to endeavour themselves by way of amends to be a help and ornament thereunto.—Bacon.



The Training of Nurses in Military Hospitals

How may this country, to which the whole world looks today for trained nurses, best and most quickly meet the national and world-wide need for adequate nursing forces to care for our sick and injured soldiers, and the reconstruction to come here and abroad, and how may we do it without depleting the nursing resources of the country? This question is scarcely second in urgency and importance to the problem of putting fighting men at the front. Several answers have been suggested, of which two chiefly have received serious consideration, namely, the training of nurses in military hospitals, and the training of nurses' aids. The government has adopted the former solution of the problem, but, we understand, only in a tentative way. Since we are all interested only in securing the best and speediest settlement of the question, and since time is of such vital importance, an unprejudiced discussion of the arguments for and against both plans should be serviceable. There are two main considerations; first, "Which plan will best meet the nation's needs, both civil and military?" and, after that—a long way after, but still very important—"Which will best serve the interests of the nursing profession?"

The nation needs at present, we are told, a nursing organization of not less than fifty thousand women—and needs them quickly. Graduate nurses it should have by all means, if possible—but a woman with training enough to enable her, under the direction of a fully trained nurse, to make a bed or put on a bandage—today—is worth more than a dozen of the most highly accomplished nurses that can be turned out in any school in the world after the war is over. The army nursing school cannot help us today, for the first of its graduates will not be seen for at least two years and four months. If the war should last that long, we shall then be just beginning to put the resources of the army nursing school to the test. Waiving for the moment the factor of immediate urgency, the questions arising in regard to the army nursing school are: From what source will the supply of pupil nurses come? How will it be trained and controlled? After the war is over, how will it be disposed of?

The supply of young women who will enter the training schools to be established in connection with military hospitals will be found, we believe, to be essentially the same as the supply that usually enters civilian hospitals, augmented by those who would not have entered the nursing profession except from motives of patriotism. The more dramatic atmosphere of the military hospital and the larger remuneration offered is going to attract from the civilian hospitals the majority of the best candidates for nurses' training. We very seriously fear that the civil hospitals, already strained to the breaking point, will be nearly or quite crippled by the establishment of training schools in the military hospitals.

As for the question of training, it is to be presumed that those responsible for the establishment of army training schools have worked out plans whereby the personnel of the supervisory forces, medical officers, and chief nurses, may be kept sufficiently stationary to give the necessary instruction; but we question whether this is not an unnecessary duplication of already existing machinery and organization for training young women under safer auspices than those of military camps.

We can see no answer to the third question, how the nurses trained in the army schools are to be disposed of after the war, except that indicated by Dr. Goldwater in the June issue of *THE MODERN HOSPITAL*. "If the army schools succeeded in attracting the number of women required to staff the military hospitals of the country during the long war," says Dr. Goldwater, "(and it must do this if it is to succeed in any large sense *without*

diverting probationers from the civil hospitals), there would be an excessive number of professional nurses in the community immediately after the war; competition would be intensified, and professional standards would be endangered."

Perhaps those responsible for the army nursing school plan have foreseen and provided against all these objections. So far, however, no adequate replies to the foregoing arguments have reached us.

On the other hand, among the advantages of the nurses' aids are that they could be organized and trained without depleting the supply of nurses needed for the protection of the public health; they could be trained in either civil or military hospitals. As they would be employed only under the supervision of graduate supervisors, they could be used as probationers or junior nurses are used, releasing many of these for service elsewhere. While they would not take three years' training, this need not interfere with the accepted standards of the three-year graduate, for, after the war is over, those nurses' aids who did not wish to enter accredited schools for further training would return to civil and non-professional life. Above all—and we see no way in which this advantage can be gainsaid or counterbalanced—we should not have to wait for over two years, while our boys are bleeding and dying at the front, for a sufficient number of women to give them needed care, and we should not be making an unnecessary sacrifice of our civil hospitals, public health welfare, and private citizens.

A Plea From the Front for Nurses' Aids

After the foregoing editorial was in type, the following letter, written to a prominent hospital man in this country, was forwarded to us by the original recipient. The writer, also one of the leaders in the hospital profession, is in command of a base hospital in France, having been "over there" almost from the time of our entrance into the war.

"For some time I have had in mind to write you in reference to the inevitable shortage of nurses if the war lasts more than six or eight months longer. It is believed that if the war continues beyond that time, our nurse personnel will have to be augmented by nurse-aids, whose training should be commenced at once.

"It is suggested that the experience of the British in that connection serve as our guide. The V. A. D.'s have certainly saved the day in the British nursing field. Their casualty clearing station and base hospital service would have broken down without their assistance. They are used as anesthetists, after some training, as nurse helpers, and even as ward nurses—with generally good results.

"It is noted that strenuous efforts are being made by leaders in the nursing profession to obtain additional

pupils for the standard three-year nurse training course. It would seem to me that this is ill advised, as the necessity for additional nurses beyond the available supply will be extremely urgent eight months or a year hence. It would seem to be better foresight to devote a part of the equipment and opportunity in existing training schools to training nurse-aids intensively for a period of six months. If aids thus trained were available, we would then be able to use graduate nurses as charge-nurses of groups of two or more wards, with one or two nurse-aids on each ward. By thus dividing the work, the quality of the nursing care would be kept up to a very good standard.

"It is believed that a six months' course, properly planned and carried out in our large civil hospitals in the States, would, in the emergency, adequately fit young women of the proper caliber for nurse-aid work. Candidates for this short period of training should be most carefully selected, preferably over 21 years of age, and the selection should be in the hands of competent training school superintendents. It is my opinion that if the opportunity for such training and service received public announcement throughout the States, there would be plenty of desirable applicants for this work.

"Knowing your breadth of vision and great influence in the hospital and nursing field, I take the liberty of calling your attention to the opportunity for service that will probably be offered if the war continues many months. You will realize that, in order to bring about definite action, it will be necessary for prompt discussion of the subject in the States, and an early understanding with the Surgeon-General's Office."

The standing and experience of the writer of this letter make comment on our part unnecessary. We hope that this plea will receive careful consideration.

A Patriotic Duty of Hospitals During the War

The United States is now in the war. The nation is getting its stride. The changes and readjustments that are required for the effective conduct of the war are difficult, and are becoming more difficult every day, but they are never impossible. Of necessity, the business of the country has been reorganized; the same imperious necessity calls for the reorganization of the civil hospitals.

Up to the present time, the enrollment of medical men has kept pace with the army's growth. But a million Americans have now taken their place in the fighting line; ships are available for the rapid transportation of a second million; a third million is streaming into the training camps, and more doctors are needed. The hospitals of the country must help to furnish them—they can if they will.

By undertaking to retain in its service only the actual number of men required to care for its patients, the hospitals can at once release a large number of physicians for army service. **EVERY HOSPITAL THAT HAS NOT ALREADY DONE SO SHOULD AT ONCE PLACE ITS STAFF ON**

A WAR FOOTING BY ABOLISHING THE ROTATING SERVICE.

What is the rotating service? It is a plan of organization which requires or permits two, three, four, or even six men, each serving six, four, three, or perhaps only two months, annually, to hold down one man's job. There may be reasons of educational policy which justify a rotating service in ordinary times; today any such plan is contrary to the national interest and is self-condemned. In this crisis no plan of organization is admissible which does not release every competent physician who can be spared for military duty. No man should be permitted to excuse himself from entering the Medical Reserve Corps on the plea that a hospital needs him, unless his presence in that hospital is indispensable—not two, three, or four months in the year, but all year.

For the period of the war the rotating service must go. The continuous service plan is the only patriotic plan of hospital organization at this time. **ONE JOB, ONE MAN!** It is the duty of hospital authorities to adopt this plan now, and to make it plain to the men who are thus released from hospital service for the period of the war that the purpose of their release is to make it easier for them to decide where the path of duty lies.

S. S. GOLDWATER,

Chairman War Service Committee American Hospital Association.

The Organized Practice of Medicine

That the practice of medicine is on the eve of a new era, which may ultimately prove to be nothing less than revolutionary in character, no one can doubt who knows the field even moderately well. This era may be termed the era of the organized practice of medicine. Manifestations of it are arising on every hand, and with increasing frequency.

This era is being ushered in by at least four outstanding influences: (1) the exigencies of the war; (2) the health education propaganda; (3) the cost of medical equipment; (4) greater financial returns to physicians.

As the war progresses, and physicians and surgeons in ever-increasing numbers are drawn into the military service, an almost unbearable burden is being thrust on those who remain. If for no other reason than that of self-defense, these physicians will be compelled to combine in some form of organization that will enable them to treat larger numbers in less time and more readily than they are now able to do. This tendency towards the organized practice of medicine is bound to receive a strong impetus after the close of the war, when the physicians and surgeons now in the service return to civil life. In cantonments and

base hospitals, they are now learning to work under orders and as parts of a great organization. This experience is bound to teach them the value of cooperation and coordination, and many will not be willing to return to the old individualistic type of practice.

The various educational campaigns for health now carried on so vigorously by national and state agencies are educating the public, not only in the fundamental laws of good health, but also to recognize and demand efficient medical service. This efficient medical service, which, as the more discriminating are fast coming to see, cannot in many instances be rendered by any one individual physician, however well trained and capable he may be.

The equipment now demanded by modern medicine for accurate diagnosis and efficient treatment is such that few physicians are in a financial position to install it in their private offices. The x-ray, the laboratory, hydrotherapy and electrotherapy apparatus, are all being called into service now. All of these it is possible for physicians to have under some form of organized practice; individually, except in rare instances, it is not. And even though they can afford to possess them, they are unable to employ them with the high degree of skill attained by men who use them daily and who are especially trained in these separate branches of modern medicine.

Furthermore, as Dr. Warner indicates in his article on the "Evening Pay Clinic," published elsewhere in this issue, under a system of organized medical practice, the average net income of physicians would be markedly greater than it is today. Dr. Warner points out that the medical profession of England was at first somewhat skeptical about the panel system for their compensation in state insurance; but it is now an established fact that these physicians are getting more money for their services than they had ever received before. When we consider that half a doctor's income is required for the necessary expense of equipment, office, automobile, etc., and that he can work for seven hours a day, at the rate of five dollars for two hours, paid in some of the existing evening pay clinics, and thereby secure the equivalent of a ten-thousand-dollar cash practice, we get some conception of what physicians could do under an organized practice.

The organization of medical practice is inevitable. What is not so clear is how physicians generally will react to it. Will they welcome it as a means of rendering a wider and more efficient service, or will they take the attitude of the hand worker towards machinery when it was first intro-

duced? Will they approach the change with a sense of inevitableness, not altogether free from apprehension and rebellion? Or will they welcome it gladly, seeing in it a larger measure of freedom from the harassing consciousness of work poorly done, often through no fault of their own, and the possibilities of a larger and more efficient service?

Vital Issues to Be Decided by Hospital People

There is some danger that, unless hospital people have their attention called to the momentous nature of the issues awaiting their attention, the approaching meeting of the American Hospital Association may be neglected. These are war times, and anything short of life and death that does not bear on the war sinks into insignificance. Hospital people need to realize that the American Hospital Association this year deals with war issues and likewise with issues of life and death.

It may very well be that the fate of the civil hospitals of the country depends on the preparedness of hospital people to decide wisely the questions which thrust themselves forward for consideration at this meeting. This is a war meeting, as the secretary announces. Now, the war is not something that the hospitals can consider solely from the point of view of the number of stars in their service flags and the number of Liberty bonds bought by their employees; it is a maelstrom in which the hospitals themselves may be wrecked unless they are guided by the most far-seeing wisdom. Dr. Goldwater sounded the note of warning in these columns last month, when he declared that "the civil hospitals of the country are being gripped by destructive forces," and called on "those who are conscious of this tendency" to oppose it in the interest both of the army and the civil population. THE MODERN HOSPITAL has pointed out more than once before and as events abroad seem to demonstrate, the morale of an army depends largely on the morale of the civil population at home. In war, of all times, we cannot tolerate sickness and the resulting inefficiency. Now, with so many of our physicians away at the front, hospitals are more necessary to the health of the community even than they are in times of peace. For the sake of victory and national preservation, therefore, we must not let the civil hospitals be wrecked. We must consider, among the other topics suggested by Dr. Goldwater, the prevention of the further breaking up of the teaching staffs of nursing schools and the relief of communities which, as a result of the war, are left without adequate medical and nursing service.

Closely connected with this is the subject, more fully discussed in another editorial, of providing a supply of nurses for our army.

Another vital topic which must, we believe, come up for consideration at this meeting is the standardization of hospitals. It is most unfortunate that just now, when their counsel is so much needed on this subject, so many of our hospital administrators should be of necessity wholly absorbed in other matters. This has thrown the burden of hospital standardization almost entirely upon others who, though just as deeply concerned for the best interests of the hospitals, are less intimately acquainted with the problems of the hospital as a whole. Admirable work has been done by the American College of Surgeons, but the college itself no doubt realizes that, to carry out to a successful issue a real program of standardization, the aid of hospital people is required. It is necessary that hospital people give the subject their most earnest consideration.

For these and many other reasons, it is most important that there be a full attendance at the Atlantic City meeting. We hope that no one will fail to realize the importance of this to the country and to the hospitals themselves.

Staff Standardization and Hospital Standardization

On another page will be found an account of the third annual meeting of the Catholic Hospital Association. As will be seen, the association has pledged itself to the hospital standardization program of the American College of Surgeons, comprising the installation of adequate case records, the abolition of fee-splitting, and the establishment of suitable laboratory facilities. When these three desiderata shall have been secured in hospitals throughout the country, the level of medical and surgical practice in them will be immeasurably raised. We extend our heartiest congratulations to the Catholic Hospital Association for thus putting itself in the forefront of progress, and to the American College of Surgeons for having pointed out the way.

We understand, however, that the first step in the standardization program contemplates the marking of hospitals on the sole basis of these three criteria, namely, establishment of case records, abolition of fee-splitting, and utilization of laboratory methods, hospitals not being graded according to degrees of merit, but marked simply as meeting or failing to meet the standard set; and we confess to being a little puzzled by such a method of standardization. The American Col-

lege of Surgeons, we understand, defines "hospital standardization" as "staff standardization"; and this definition, too, puzzles us a little. In the first place, "hospital standardization," to hospital people, means, as a matter of course, standardization not merely on the basis of medical and surgical care alone, but on the basis of everything that can affect the patient's safety and well-being—adequacy of nursing service, construction of buildings, organization of housekeeping service, and soundness of financial methods. In the second place, many hospitals, owing to local conditions, are unfortunately so dominated by self-seeking staffs that to propose to mark the hospital on the basis of staff efficiency alone seems somewhat like the proposition of a school inspector to pass or not to pass the pupils on the basis of their parents' intelligence. It is quite true that to pick out intelligent parents is about the best thing one can do to lay the foundation for a good education; but it might seem discouraging to tell a child that all his subsequent devotion to grammar and arithmetic and geography, etc., count for nothing. Similarly, we fear that marking on the sole basis of staff efficiency may be a little discouraging to a hospital in which a hard fight has been waged—perhaps against an indifferent board and a neglectful staff—for efficiency in all hospital essentials.

Seriously, we hope that any organization which may undertake to standardize hospitals will do so with the broadest and most enlightened conception of the task. The reform of staff abuses which the American College of Surgeons has undertaken cannot be too highly commended; it is perhaps the one essential preliminary to the successful standardization of hospitals. But we fear that a standard based on staff efficiency alone will inevitably be found so inadequate and unsatisfactory as to lead to the establishment of some rival system of standardization. We hope that this most undesirable complication may be avoided.

Consolidation of the Editorial and Business Offices of The Modern Hospital

This number of THE MODERN HOSPITAL is issued from the new address, 58 East Washington Street, instead of 111 West Washington Street, and by the time this copy reaches its readers the consolidation of the editorial and business offices at the foregoing address will probably have been completed. It has become increasingly clear as time went on that THE MODERN HOSPITAL could render more efficient service to its readers by a closer departmental cooperation, particularly

between the editorial and statistical departments, than was possible when these were separated by the distance between Chicago and St. Louis. All departments formerly situated in St. Louis, therefore, have been removed to Chicago and are now under one roof with the editorial department.

THE LATCHSTRING OUT

THE MODERN HOSPITAL is now "at home" to its friends in its new offices at 58 East Washington Street, suite 1419.

It is our fervent hope to induce Dr. C. E. Sampson of Cottage Hospital, Creston, Iowa (mentioned in the "Field Editors' Notebooks" this month), to write down what he told us on a recent visit here about the tribulations of a hospital that aspires to be a community center, while beset by politicians that "wrap themselves in the stars and stripes and make a noise like a patriot." In order to maintain his hospital as the educational center for which it was intended, Dr. Sampson has had to organize all the progressive enlightened forces of his community, and even to buy and run a newspaper.

Dr. F. K. Camp, superintendent of Wesley Hospital, Oklahoma City, believes that his institution has a service flag that can compare with that of any hospital of its size in the United States. Wesley Hospital, at the time we had the pleasure of seeing Dr. Camp, had sent to serve under the colors fifteen physicians, including the chief of staff, and ten nurses, with ten more to follow. The medical staff consisted of one man who could not pass the physical examination for the army, having had infantile paralysis, another over the age of fifty-five, and two women physicians. Dr. Camp himself has informed the government that he is ready to close the hospital and go to the front himself whenever our government says the word.

Dr. E. H. Lewinski-Corwin, who has been selected to direct the study of the dispensaries of New York City for which the Rockefeller Foundation voted ten thousand dollars to the public health committee of the New York Academy of Medicine, when in Chicago recently, kindly furnished us with the following outline of the questionnaire which he has prepared for use in this investigation:

Total number of dispensaries connected with hospital.

Chronological table showing dispensary treatments, diseases treated, etc.

Record number and total number of patients.

Legal proofs concerning dispensary service and staff. This would include staff and various clinics open throughout the year and hours at which clinics were operated. Number of physicians available at certain periods of the year, say in August, September, April, etc.

Total number of pay and nonpay patients.

Total number of paid and unpaid physicians. Length of service.

Special service, dental, etc.

Could patients contribute more and should they?

What is known of financial standing of patients?

Relation of the Out-Patient Department to the hospital.

Organization of methods of handling patients to reduce waiting time of patients (lectures, pictures, and luncheons for patients while waiting).

Medical Histories, manner of taking histories, recording, etc.

Influence of evening clinic.

Equipment of evening clinic.

Service of evening clinic.

Dr. Rosetta Sherwood Hall, who for over twenty-five years has worked as a medical missionary in Korea, on

a recent visit here told us most interesting things in regard to hospital conditions in that far-away land.

The hospital shown in Figure 1 was built in Pyeng Yang, Korea, by Dr. Hall in 1909. Dr. Hall was compelled by force of circumstances to be the architect, chief contractor, and "boss" carpenter, for the masons were Chinese, and the Korean carpenters had never seen such a building. The governor of Pyeng Yang was invited to



Fig. 1. The Hospital of Extended Grace to Women and Children, designed and built by Dr. Rosetta S. Hall at Pyeng Yang, Korea.

name the hospital, and out of gratitude to Dr. Hall for having cured his wife, he called it "The Hospital of Extended Grace to Women and Children." She has been good enough to write a little paper on the subject, which will be published in an early number.

The second illustration shows Dr. Hall in her consultation room, with a glimpse beyond of the treatment room, where an assistant is giving a throat treatment. To the right stand two attendants who receive and check the



Fig. 2. Dr. Hall in her consultation room in the Hospital of Extended Grace.

shoes of the Korean patients as they enter, much as attendants in public places here check outer wraps and men's hats. Among the customs which Dr. Hall thinks we might well learn from the Koreans is that of keeping floors free from street dirt and the marks of shoe-nails. Korean floors are kept clean enough to eat on and sleep on, and are used for both purposes.

The two attendants just mentioned are both blind. The condition of blind girls in Korea is extremely pitiable, for according to native heathen custom they are left in ignorance, or are sometimes trained as sorceresses or

fortune-tellers. Dr. Hall's interest in the blind girls of Korea was early awakened, and in 1897 she perfected her system, adapting New York Point to the Korean language, and embossed the first books for the Korean blind before the apparatus arrived from New York.

The third picture shows the children's ward in the Hospital of Extended Grace. It is named the "Edith Margaret



Fig. 3. The Edith Margaret Ward in the Hospital of Extended Grace.

Ward" in memory of Mrs. Hall's little daughter. The picture was taken in the winter of 1909-10, before the wards for adults were in use. The patients, it will be seen, are on this floor. Korean floors are not only clean, but artificially warmed, and Koreans regard it as a great hardship to have to sleep on chilly "foreign" beds. While there is a "foreign bed ward" in the Hospital of Extended Grace, Dr. Hall has found the warm floor beds so advantageous, particularly in postoperative cases, that she has put them in general use.



Fig. 4. This group shows, from left to right, seated, the two Drs. Kim and Dr. An, the first three women to graduate from the government medical school at Seoul, Korea; standing, Dr. Rosetta S. Hall, Prof. Okada, Dean Sato, and Dr. Mary M. Cutler.

The fourth picture shows the first three women to receive a degree from the government medical school in Seoul. In the upper row, on left (reader's) stands Dr. Hall and on the right a colleague, Dr. Mary M. Cutler, while in the center are two Japanese officials. Dr. Hall found the Japanese very broad-minded and helpful—more so indeed, than Western physicians—toward the plan of educating Korean women as physicians. Women physicians are necessary in Korea, for custom does not permit women to receive medical attention from men.

Worry is rust upon the blade.—Henry Ward Beecher.



Fig. 1. Members of the Catholic Hospital Association assembled

PROGRESSIVE ACTION TAKEN BY CATHOLIC HOSPITAL ASSOCIATION

Washable Uniform for Sisters, Controlled Staffs, Adequate Case Records and Laboratory Facilities Approved—Fee-Splitting Condemned—Some of the Papers Read—A Notable Meeting

The Catholic Hospital Association met in Chicago, June 18, 19 and 20 at St. Xavier's Academy. The sisters of St. Xavier's deserve warm thanks from the association for the way in which they arranged accommodations for the visiting sisters and guests. Over two hundred Catholic hospitals, representing several of the sisterhoods who are consecrated to the care of the sick, were present.

The meetings opened with a mass in the chapel of the school, attended by all the hospital delegates, priests, sisters, and guests of the association.

The Rev. Father Charles B. Moulinier, S. J., regent of the Marquette University School of Medicine and president of the Catholic Hospital Association, delivered the opening address. Father Moulinier has given the greater part of his time during the last few months to the study of hospital conditions. He is heart and soul in the work of betterment of the Catholic hospitals. His address is published herewith.

Mr. John G. Bowman, director of the American College of Surgeons, explained the purposes of the movement undertaken by the college for the standardization of the hospitals and something of the fundamental things which the college believes to be necessary to give the very best service to the patients. Mr.

Bowman told of some of the abuses current in hospitals today which could be eliminated by the keeping of complete case records and their use by the staff and the governing authorities to keep watch of the grade of work being done by the medical men who bring patients to the hospital.

Dr. A. J. Ochsner, F.A.C.S., of Augustana Hospital, Chicago, read a paper on "The Model General Hospital," which is published following the report, illustrated with

a wall chart showing a plan for the organization and control of various departments, some by the superintendent and others by the direct administration of the staff. Among the latter were the training school and the superintendent of nurses.

Dr. Roger T. Vaughan of Cook County Hospital, Chicago, had for his subject "The Importance of Autopsies." Dr. Vaughan gave important data to prove the value of autopsies in final diagnosis, and read considerable history on this matter to show that the making of autopsies was not disapproved by church authority.

Dr. William Carpenter McCarty, of the Mayo Clinic, Rochester, Minn., brought to the association much valuable information concerning the laboratories and the work of the technicians at St. Mary's, that famous hospital which is conceded to be an authority on group diagnosis.

"The Hospital's position in the Education of the Doctor" was presented by Dr. Fred C. Zapffe, secretary of the Association of American Medical Colleges, Chicago.

Dr. William J. Mayo of Rochester, Minn., who was to



Fig. 2. Rev. Charles B. Moulinier, S.J., regent Marquette University School of Medicine, president Catholic Hospital Association.



for the third annual convention at St. Xavier's Academy, Chicago.

have opened the second day's meeting on Wednesday, was not able to be present.

"Group Diagnosis and Treatment" was discussed in detail by Dr. Louis F. Jermain of Milwaukee, Wis.

Dr. Joseph Byrne of the Neurological Hospital, Blackwell's Island, N. Y., gave an interesting talk on "The Patient's Mind and The Importance of Social Service for the Future Welfare of the Patient." Dr. Byrne, with a sympathetic understanding of his subject, dwelt on the necessity of the study of the neurological patient from the human as well as the scientific standpoint.

Dr. Charles E. Paddock of St. Luke's Hospital, Chicago, Ill., read an exceptionally good paper on "The Hospital and Obstetrics—The Saving of the Seventh Baby."

"Better Care of the Physical and Mental Health of Sisters and Nurses" was urged by Dr. Charles M. McKenna of St. Joseph's Hospital, Chicago. Dr. McKenna suggested more frequent and thorough general physical examinations for the women engaged in hospital work.

The Thursday session was opened by Mr. John G. Bowman, who spoke on "The Business of Medicine and the Profession of Medicine." An abstract of his address will be found on succeeding pages.

The following resolutions were adopted by a rising vote and without any dissent or discussion. They will form part of the platform of the Catholic Hospital Association.

1. *Resolved*, That we, the Catholic Hospital Association of the United States and Canada now assembled at Chicago in our third annual convention, approve of the work being done by the American College of Surgeons for the standardization of hospitals and assure the College of our fullest cooperation in its endeavor for the betterment of hospitals and the resultant increased welfare of mankind.

2. *Resolved*, That we, the members of the Catholic Hospital Association now assembled in Chicago, do hereby declare our desire to adopt

a washable uniform or gown, along with a curtailed veil, to be worn when in actual service of the sick, in so far as it will meet with the approval of our superiors and be in keeping with the spirit and traditions of our respective orders or congregation and meet with sanction of ecclesiastical authorities.

3. *Resolved*, That we, the members of the Catholic Hospital Association call upon all of our members who are sisters to become, as far as practicable, registered nurses; and to establish training schools for nurses wherever and whenever practicable. To the various state boards of our respective states and provinces we pledge our determined efforts to cooperate in maintaining the highest reasonable standards in our training schools for nurses and in all other health service that comes under their jurisdiction, and within the sphere of our activities.

4. *Resolved*, That we, the members of the Catholic Hospital Association, pledge ourselves to organize controlled staffs in our hospitals; to establish or continue an adequate system of case records, with a sister in charge, having full authority to demand the careful cooperation of doctors, interns, and nurses; and to require of our staffs a monthly or bimonthly analysis of these records; to secure from our superiors, staffs, or friends funds to properly equip all necessary laboratories and to bring about as soon as possible the scientific training of our sisters and technicians of all kinds, anesthetists, dictitians, record-keepers and social service experts. We further pledge ourselves to urge all surgeons who are privileged to practice in the hospitals of the association, and who are not at this time Fellows in the American College of Surgeons, to qualify, as soon as they are able, for Fellowship in the college. We further wish to express our desire that all doctors who practice in our hospitals be or become, as soon as practicable, members in good standing of their respective county medical societies and contribute their share to the active medical life of said societies. We further wish to express

our conviction that the secret division of fees as condemned by the American College of Surgeons is an unethical and nefarious practice which we pledge ourselves to keep out or root out of our hospitals.

The following officers of the association were elected for the coming year: honorary president, Most Reverend Sebastian Gebhard Messmer, D.D., D.C.L., archbishop of Milwaukee; president, Rev. Charles B. Moulinier, S.J., regent, Marquette University School of Medicine, Mil-



Fig. 3. Sister Mary Joseph, St. Mary's Hospital, Rochester, Minn., first vice-president Catholic Hospital Association.

waukee; first vice-president, Sister Mary Joseph, St. Mary's Hospital, Rochester, Minn.; second vice-president, Sister Mary Esperanz, Minneapolis, Minn.; third vice-president, Sister Mary de Pazzi, Toronto, Ontario, Canada;



Fig. 4. Dr. B. F. McGrath, Marquette University School of Medicine, Milwaukee, secretary-treasurer Catholic Hospital Association.

secretary and treasurer, Dr. B. F. McGrath, Marquette University School of Medicine, Milwaukee; executive board, Dr. Joseph Byrne, Fordham, New York; Sister Mary Regina, Wilkes-Barre, Penn.; Sister Mary Constance, Baltimore; Sister Mary Ursula, Ann Arbor, Mich.

PAPERS READ AT THE CATHOLIC HOSPITAL ASSOCIATION CONVENTION

The following are some of the papers read at the Third Annual Convention of the Catholic Hospital Association. Others will be presented in later issues.

President's Address

By REV. CHARLES B. MOULINIER, S.J., Regent of Marquette University, Milwaukee.

This is our third annual convention of the Catholic Hospital Association.

In the first convention we gave our best efforts to bringing clearly before our minds the great fundamental fact that a hospital is an educational institution, just one factor, and that a very large factor, in medical education. No matter where the hospital, no matter what its size, no matter what its other struggles, there was just one constant duty to perform—the educating of every one in the hospital, from the highest surgeon to the merest orderly or engineer, in the matter of taking proper care of the sick. The doctor must learn and teach all the while in everything he does, whether surgeon or internist. The intern, if there be any such in the hospital, must be learning and teaching all the while. The nurse, from the probationer to the graduate, must be learning and teaching all the while. The laboratory technician, the clerk, the superintendent, the orderly, the engineer, must be learning and teaching all the while just one thing, namely, how to take ever better care of the patient. The patients, every one, from the youngest to the oldest, man, woman, or child, must likewise be learning and teaching all the while, learning how better to take care of self and teaching in one way or another every member of the staff, of the

intern force, of the nurses, of the managing personnel, how they have succeeded or failed in doing all they could and should have done to help the patient to get better, to be cured, and to remain healthy when he or she leaves the hospital. More knowledge of medicine, therefore, is learned and taught in the hospital than in any other of the institutions concerned with the study of human health.

In our second convention we spent three days discussing the theme of team-work in the hospital. We pictured the whole hospital procedure as a game in which the prize or trophy struggled for was the alleviation or cure of human ills—the bringing into the life of every patient as far as medical knowledge could avail, of comfort and pleasure and health of body, mind and soul, not only for this life but even, where possible, reaching out into the life to come.

In both of these previous conventions there was always one overmastering, controlling point of view, *service to the patient*. We never lost sight of the great fundamental, ethical principle that the patient has a right to all the most enlightened, self-sacrificing, scientific, philanthropic, and conscientious religious service that body, mind, and soul of man crave for, need, and have a right to. We repudiated any such thought as that the hospital is a mere boarding-house, a place where the surgeon merely operates, where the internist merely prescribes medicine or treatment, where the nurse is little more than a cheerful attendant on whims, where the intern comes and goes in his white uniform in the performance of perfunctory duties, where the sisters and the chaplain are pleasant and courteous and unobtrusive; and we have taken up with vigor and are now pursuing, after one year of interruption in our meetings, with renewed energy the whole-souled conviction that the work of caring for the sick in our hospital is one of the most complex, serious, coordinated, and exacting functions that any profession today is called upon to perform in behalf of its fellow man. Furthermore, if what we have said in our previous two conventions be true, we are now logically and inevitably face to face with a question just as complex, just as serious, just as heart-searching and conscience-disturbing as any that can be put to an individual human being or responsible aggregate of human beings, and the question is this:

Are you performing your full duty to the sick as bound to do by the laws of man and of God? Are you and your hospitals and your staffs and your interns and your nurses and your technicians and your dietitians and your record-keepers and your clerks and your cleaning maids and orderlies and your engineers and all your helpers—are they, one and all, doing what they can and should for every patient that comes into your hospitals?

If they are, then you should rejoice in heart and mind and conscience and go right on ever keeping pace with the growing truth of medical scientific knowledge and general hospital service. If they are not, then here at this third convention of the Catholic Hospital Association you must think and search and find out where, in what, and why that full and best service is not being given in your hospital and, if possible, determine before this convention adjourns that whatever is right and good in your hospital will go on becoming more right and better, and whatever is poor or bad will be made good and better just as soon as ability, determination, and concerted effort on the part of all concerned, superior, staff, intern, nurse, technician, clerk, orderly, can be brought to understand and appreciate the sacred obligation resting upon all to give the highest possible service to the sick.

This, my dear fathers, sisters, nurses and doctors, is

what standardization means in the mind of the American College of Surgeons, in the mind of its high-souled director, Dr. John G. Bowman. This is what it means in the mind and soul of the members of the Catholic Hospital Association. This is what any true, effective, and lasting standardization must mean. It means, therefore, I go on to explain, a gathering together into our minds and hearts and characters a few fundamental and far-reaching principles and convictions, a few strong and vital motives, and a few impelling, mastering determinations all converging with harmonious cooperation on the one great achievement to bring into the physical, mental, spiritual, and religious life of every patient within our hospitals the fullest possible measure of helpful service.

We are here taking part in these three days' deliberations with a view to coming as nearly as we can to a uniformity of view on certain great phases of hospital work. We are really going to try to get at the philosophy of hospital service and we are going to make a concerted effort to understand the SOUL of the hospital. As you listen to the various speakers, as you gather during the noon recess and in the evenings, as you talk over in the conferences the many and varied facts and factors that enter into hospital life, I beg of you never to forget in it all that the hospital has a soul, a spirit, a breath, and a life which is distinctive, which is vulnerable, which can be killed. To bring out just what I mean, permit me to go a little further and to say that there are today in this country strong, robust, living hospitals; there are dying and dead hospitals; and it is all a question of the spirit, of the spirit of service, of true service, of unselfish service, and the heart and the hand and the daily wearing of body of enlightened service, of service into which go the mind and soul on the part of every one concerned, in no matter how insignificant a way, with the care of the sick. And it is this soul, this life, this spirit of the hospital that we are going to study these three or four days in order that we may understand the mind, the heart, the altruistic purpose of the great American College of Surgeons. I say "great" advisedly because they are showing a greatness of mind and purpose in their unselfish effort to bring all the hospitals of this country and of Canada to understand and appreciate from year to year ever more truly and keenly what high degree of service can and should be given to the patient in the hospitals of the United States and of Canada.

The whole world is to be the beneficiary of these efforts. The patient, the doctor, the nurse, and all concerned in this great struggle to make this mortal life of ours a healthier, a more enjoyable, and a better life morally and religiously.

We shall make every effort, I know, to get at the truth of things medical that enter into hospital life and we shall unflinchingly accept whatever burden this enlightenment brings to our future efforts in hospital service.

The Business of Medicine and the Profession of Medicine

SUMMARY OF AN ADDRESS BY JOHN G. BOWMAN, Director of the American College of Surgeons, Chicago.

Francis Bacon observed some four hundred years ago that the doctor owes a debt to his profession. Since that time doctors have liked that observation; over and over they repeat it. But what is the debt to the profession which the doctor owes? Or, to state the question in another way, what is that the doctor owes to his profession that the business man or the iceman does not owe to his work? On this basis is there an essential distinction between a doctor and an iceman?

The doctor and the iceman have many qualities in common. Both exert physical energy in their day's routine. Both become tired and discouraged; both have their moments in the day's round when they realize some compensation for their efforts outside of a monetary one.

Both the successful doctor and the successful iceman are intelligent. Any distinction between the two in the matter of intelligence is one of degree. But for centuries there has lodged in the public mind a distinction between the doctor and the iceman. Tradition holds that the doctor goes to his day's work with an altruism which does not exist in the heart of the iceman. The doctor, according to this view, assumes an obligation toward his fellow-beings which the iceman, admittedly, does not assume. The doctor is under obligation to consider the interests of the public as well as his own. Are you satisfied with this distinction?

The war has brought about some quick revision of popular notions. An ideal of service is shot into all of us. Dominated by this spirit the icemen, it seems, recently held a convention in New York. They pointed out with sincerity that they are benefactors of humanity; that by their efforts they save a useful commodity which would otherwise go to waste; that by the distribution of ice they save food and relieve human suffering; that they render a service comparable to that of our highest professions.

We find ourselves proud of the iceman. The iceman renders a service to humanity; so do the white-wings who sweep the streets. White-wings prevent disease. Icemen, white-wings, and doctors usher in human happiness. Service to humanity, therefore, is not a distinguishing quality of the doctor. Neither can we differentiate the doctor's service from the service of the trades on the ground that the doctor gives, to a large extent, his services free to the poor. Grocers also give free food to the poor and icemen give free ice to many a mother in order that she may keep milk sweet for her children. What, therefore, is the special debt which the doctor owes to his profession?

In answer to the question, first, the doctor ministers to his fellow-men at the extremity of life. His patient is not in normal health. Many times he is close to death and his mind does not function in its normal fashion. The patient is defenseless. He must trust the doctor more absolutely than he has ever been called upon before to trust his fellow-man. He places his very life in the hands of the doctor. The first debt which the doctor owes to his profession is, therefore, that he have lodged in his own heart the essential character worthy of this highest trust of which we can conceive.

Second, by the very nature of the doctor's work he owes a degree of honesty to his fellow-man that distinguishes him from all other folk. The defenseless patient trusts the doctor utterly. Does the doctor give to his patient the benefit of the highest knowledge in medicine? Is he scientifically honest? Does he bring to bear upon the complaint of the patient every laboratory analysis and benefit of thorough physical examination which may throw light upon the cause of the complaint? Does he follow the development of the case hour by hour, or day by day, if need be, in the same spirit? In the answer to these questions lies a trust, the height of which is not reached in any trade or business. The doctor's debt to his profession is that he be qualified by training to answer these questions with sound science; that he follow his judgment with performance; and that he have the character to inform his patient promptly of any inability on his own part to meet the trust placed in him.

The General Hospital

By A. J. OCHSNER, M.D., LL.D., F.A.C.S., Chicago.

There are certain fundamental principles which must be borne in mind constantly in order to make a general hospital perform its highest mission in efficiency and humanity.

The element of precedent, although valuable, must not be permitted to prevent progress. It would show as little wisdom were we to attempt to harvest the great crop of wheat in our Northwest by hand with the sickle because our ancestors did this half a century ago as it would show should we attempt to conduct our hospitals as they were conducted during the same period because of precedent.

While we are wise to make use of modern farm machinery, on the one hand we must not accept the wasteful ways that have come with the new way of doing things, neither should we abandon one single good trait of the old hospital management. Above all things, we should not permit the element of human interest in the patient and those in distress over his illness to be neglected because of our ability to deal with his malady in a more scientific way. By insisting upon having your sister superior of each and every institution a woman with this deep human interest, you can for all times continue to maintain this as one of the characteristics of our Catholic hospitals in the future as you have in the past.

There are two elements which sometimes, though very rarely, have crept into these institutions because of the personal characteristics of the one at the head of the hospital. Occasionally, she has been too much inspired with the idea of material growth of the institution and has placed the financial side above all others; still more rarely it has been the desire to give the religious side of the work due prominence, not appreciating the fact that by exercising human interest the highest form of religion can be served. In the future a third element might be introduced because it is so common among many of the most highly trained members of the medical profession, namely, the practice of becoming so completely engrossed with the scientific interest in the disease as to forget completely the patient and his human interests.

Fortunately, heads of the hospitals with these unfortunate tendencies can be placed in positions outside of hospital management where the very peculiarities which make them undesirable in the one institution will make them especially desirable in some other.

With one of the most common faults of many of the modern hospitals, the element of wastefulness and extravagance, we need not be concerned so far as the management of Catholic hospitals go, with the exception of the wastefulness of the medical and especially the surgical staff, which is very difficult to control in any institution. In the respect of eliminating waste the Catholic hospitals stand at the head through wise and painstaking administration.

Most of our hospitals have grown from very small beginnings, and consequently conditions had to be improvised in every detail. The next generation will come into fully established institutions, and it is important that now you see to it that an efficient organization be developed so that these institutions will be able to exercise the greatest possible good for the coming generations.

HOSPITAL STAFF

One of the most important elements is a thoroughly competent hospital staff. In the early days an institution

demanding such a staff would have been disappointed in our present comprehension of the qualifications for members of this body.

Within the period of a few years, it seems likely that the following qualifications will be demanded by hospitals of the members of their staffs.

They must be men above reproach from the standpoint both of morals and ethics. Hospitals will be unwilling to have on their staffs a moral degenerate or a fee-splitter or a man who treats his professional colleagues unfairly no matter how capable he may be professionally, because they will feel that they have no right to expose the younger members of the profession upon the staff to the evil influences of such a man, and because they will refuse to be classified with institutions willing to sanction this.

Regarding professional ability and educational qualifications, we are bound to be in a transitional period for a number of years to come. Undoubtedly, many of the most capable men in the medical profession of today have not enjoyed ideal educational advantages, but they have made the best of the available advantages, and the results have been quite remarkable in many instances.

For the present generation all such men should be given every opportunity to exercise their skill in our hospitals. Here the element of loyalty which has been so marked in the past in Catholic hospitals will come into play. A member of the medical staff who has loyally stood by the institution during the days of its struggles should not be dropped by the wayside because under his care and support the institution has grown to a position in which it can command men of greater educational qualifications. This man would, however, not be permitted to keep the professional side of the institution at the level of his educational standing by filling vacancies which may occur with men of the same educational type.

If your hospitals will insist invariably that every new member of the staff be of the highest type morally, ethically, intellectually, and professionally, time will do the rest. In order to do this, two elements must be introduced. You must have a definitely organized staff with a chief of staff, a chief of every department, associates and assistants, and a house staff, and at the present time, I believe, it is well to have a visiting staff. The visiting staff should have privileges but no rights. It should serve the purpose of giving desirable members of the medical profession an opportunity to demonstrate their ability in order to enable the staff to choose wisely when opportunity comes to fill vacancies in the regular staff. The members of the regular staff should have rights as well as privileges. They should recommend through their chief to the sister superior all matters pertaining to the medical side of the conduct of the institution.

In case of vacancies, they should recommend but not appoint men to fill these places. At this point, I wish to introduce an important principle which has been employed in European universities for many generations. In filling vacancies the staff should in each instance recommend to the sister superior not one, but three, candidates, indicating them, if desired, as first, second, and third choice. The sister superior should confer with the head of the department in which a vacancy is to be filled, or, if the head of the department is to be filled, with the various heads and the chief of staff, and then she should choose one of the three or reject all of them. In this manner the staff cannot force the sister superior to accept a particular man against her judgment neither can the sister superior force upon the staff an undesirable member.

QUALIFICATIONS FOR STAFF MEMBERS

Above all things a staff member must be morally and ethically beyond reproach, and every one of the new members for the junior positions should have the best possible educational qualifications. They should have an excellent preliminary education, a thorough scientific college and first-class medical college education.

Those occupying higher positions should have served as interns and then as assistants and whenever possible they should have broadened their education by study abroad extending at the least over a period of one year.

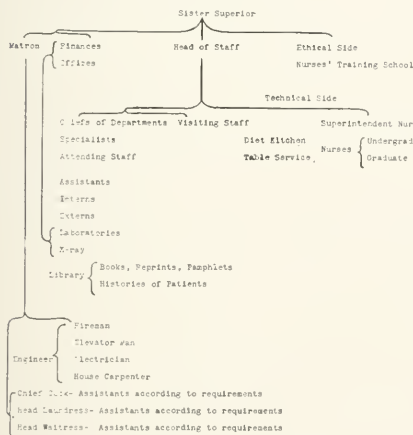
They should be chosen without regard to their religious affiliations. Should you limit your choice or even favor the choice in selecting staff members to those of the Catholic faith, the institutions would not attain the highest efficiency because of what might be called harmful in-breeding.

Undoubtedly, it will be necessary after some years to introduce the elements of age limit or limit of period of service in order to strengthen the staff, and maintain the highest degree of efficiency. At present we need not insist on the introduction of these elements.

LINES OF AUTHORITY

No modern business would prosper unless it had established definite lines of authority. In order that everyone connected may know his part of the business and mind it, I would suggest the accompanying outline.

LINES OF AUTHORITY FOR GENERAL HOSPITAL



NURSES' TRAINING SCHOOL

The greatest advance in hospital management during the past century was the introduction of the nurses' training school.

In the larger cities the Catholic hospitals have an opportunity to establish a system which they may conduct, preferably in connection with any or all of the other hospitals in the city, but, to begin with, it might be best to start without reference to the others unless it were possible to interest one or more at the outset. I will submit for your consideration the following plan, which will, I think, solve many of the educational difficulties you have encountered in conducting your training schools.

There should be a central school in each city, with a teaching force composed of the best teachers from the

various training schools. Two sessions should be held each day, one from 9 a. m. to 12 m., and the other from 2 to 5 p. m. The work in the afternoon should be a repetition of the work in the morning in order that all of the nurses should have exactly the same instruction.

All first-year nurses in the city should be divided into Groups A, B, and C.

Group A should be divided into two halves, and this entire group should attend the central school from 9 a. m. to 12 m. One-half of Group A should go on duty in a hospital at 1 p. m. and work until 7 p. m., and the other half should go on duty at 5 p. m. and work until 11 p. m. The afternoon work is heavier between the hours of 5 and 7 o'clock. There should consequently be as many nurses on duty at this time as during the forenoon hours. Groups A and B should contain each two-fifths, and Group C one-fifth of the total number of nurses.

Group B should go on duty in the hospital at 7 a. m. and work until 1 p. m., and then this group should attend the central school from 2 to 5 p. m.

At the end of every month half of group A would exchange places with Group C. At the end of six months Group A and Group B would change places. In this manner all of the members of Group A would have their night duty during the first six months, while the members of Group B would have night duty during the second six months of the year.

EDUCATIONAL PROVISIONS

Every hospital should represent an important element in the educational system of this country. It is unreasonable to permit the wonderful educational facilities to be wasted which will be available when every member of every hospital staff shall have been selected for his high moral, ethical, educational and professional qualities. Such forces should be employed systematically and universally in the education of the future members of the medical profession.

If we give our attention to this element with intelligence and judgment, we shall have at our command without cost the most powerful means of educating the coming generations.

The work will have to be systematized. A plan has been in operation in two of my hospitals for a number of years which has brought most gratifying results, which could be employed by every Catholic hospital in the country and would place your medical colleges in the front ranks. The system consists in assigning one or more medical students for service in the hospital to each regular intern to assist in every detail of his work, with no responsibility except to obey orders, the intern taking the entire responsibility.

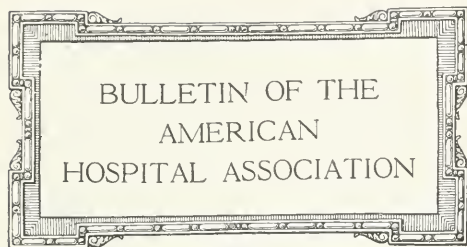
The extern gives his entire time to this work for three or four, six, or eight months, according to the division of the school year into quarters or semesters, or, according to the plan just introduced, quadrimesters. This service should be taken between the second and third school year and again between the third and fourth.

Students who have taken this work in our hospitals in the past have invariably become leaders in the profession because of their intimate contact with the patient and the medical staff before completing their college work.

We have a weekly conference for all interns and externs, which adds to their enthusiasm as well as to their understanding.

Many important details cannot be discussed here, but the opportunity is before you and should not be wasted.

No one is useless in the world who lightens the burden of it for someone else.—Charles Dickens.



Monthly Bulletin issued from the Executive Offices
728 Seventeenth Street, N. W., Washington, D. C.
HOWELL WRIGHT, Executive Secretary.

APPOINTMENT OF TEMPORARY EXECUTIVE

An Open Letter From the President of the American Hospital Association to the Members

To the Members of the American Hospital Association:

Hospital war problems will be the keynote of the meeting of the American Hospital Association in Atlantic City, September 24-28, 1918. If well attended and successful it will be the most important meeting the association has ever held. Hospitals are facing more vital problems today than ever before—problems which can be settled, adjusted, or met only by unified, concerted action, problems far-reaching and many sided, resulting directly from the war, which can be understood only through extended discussion and by aid of those in authority who can give fundamental facts and reasons. It is the public duty of the hospitals of America to take part in this meeting and thereby contribute to its success. No hospital can afford to be without representation. It is the obvious duty of the trustees of every hospital to arrange for the attendance of a representative.

Our secretary, Dr. William H. Walsh, who for some time has been in the Surgeon General's office, was, in May, ordered to Camp Grant to assemble and become the commanding officer of Base Hospital No. 58. General plans for the commercial exhibit and for the program had been worked out, but there remained much work to make them accomplished facts. A temporary executive was, therefore imperative.

On June 12 the trustees of the association met in Washington at the call of the president to consider the situation. Dr. Walsh was given indefinite leave of absence without pay. The president and the first vice-president were authorized to present the situation to the Cleveland Hospital Council and, if possible, secure the part-time services of Mr. Howell Wright, its executive secretary. Recognizing the importance of the situation to the American Hospital Association, the Cleveland Hospital Council consented to give up the services of Mr. Wright to such an extent as is necessary to carry on the essential work of the association. The formal letters arranging this cooperation with the Cleveland Hospital Council follow this communication and are commended to your attention.

In recognition of the often repeated suggestion that the American Hospital Association should be an association of hospitals, with hospital or institutional membership as well as individual membership, the trustees authorized the appointment of a special committee to give consideration to this subject and report its recommendations at the convention. The personnel of this committee as appointed by the president is: chairman, Dr. A. R. Warner, super-

intendent Lakeside Hospital, Cleveland; Mr. Michael M. Davis, Jr., director Boston Dispensary, Boston; Mr. Richard P. Borden, trustee, Union Memorial Hospital, Fall River, Mass. The report of this committee will be printed and published prior to the convention, and copies sent to all the members for consideration and study. The recommendations of this committee should have an important bearing upon the future development of the association.

The hospital problems of today are not alone individual problems. They are the hospital and health problems of the nation at war. They require discussion and deliberation. They demand concerted action for adjustment and solution. They constitute the basis of the program of the meeting. The president appeals to the members of the association to join in this opportunity for patriotic service.

ARTHUR B. ANCKER,
President American Hospital Association.

June 13, 1918.

Mr. Howell Wright, Executive Secretary, Cleveland Hospital Council, Cleveland.

Dear Sir: As president of the association, I have been authorized by the trustees to complete arrangements with you whereby you shall become the executive secretary of the American Hospital Association temporarily if the Cleveland Hospital Council shall consent to this arrangement. It is needless to discuss at this time the need of the Association for an executive secretary to carry out the plans and arrangements for the forthcoming meeting. These plans in general are determined. We desire an executive to accomplish them. Realizing the difficulties in combining this work with your present responsibilities, you are hereby assured that you will have the cooperation and support of myself and the trustees and there will be no disposition to make your work difficult by unnecessary instructions or interference of any kind. You will be the accredited executive officer of the association with all the privileges and responsibilities which usually accompany executive positions. We will ask results only.

In consideration of the above services the American Hospital Association will pay you \$100 per month for the time you serve it and also allow you all necessary personal expenses incurred by you in carrying out this work.

Yours very truly,

ARTHUR B. ANCKER,
President American Hospital Association.

June 15, 1918.

Dr. Arthur B. Ancker, President American Hospital Association,
St. Paul, Minn.

My dear Dr. Ancker: I have given most careful consideration to your letter of June 13. Although the Cleveland Hospital Council has consented to loan my services to the American Hospital Association temporarily in the capacity of executive secretary, I personally have hesitated to give my consent to the arrangement.

My ambition is to be in a position to perform some service of real value in connection with the war. I have had some slight opportunity for such service as secretary of the Cleveland Hospital Council. There is no present indication that my acceptance of the position of executive secretary of the American Hospital Association will afford any added personal opportunity for war service. I hope, however, that the immediate future will develop other conditions which will present to the association and to me personally opportunities to contribute more extensively to such service.

Among other important plans and policies, the Cleveland Hospital Council is committed to the proper development of its new purchasing bureau and to a very definitely worked out legislative program. This latter includes my candidacy for nomination and reelection to the Ohio Senate. I must do my part in carrying out this and the other policies of the council.

The chief work apparently expected of me, as suggested in your letter, is to complete plans and arrangements for the forthcoming convention at Atlantic City. If I were entirely free to do this work only, it would not be particularly difficult but added to all the rest of my work it will be considerable of an added strain in that it will require traveling and the transaction of business from Cleveland through the office of the association now located in Washington. However, for a period of a few months I will endeavor to handle this situation in this way, if necessary.

Although the indication is that there will be no added personal opportunity for real war service work in my taking on this new position, I would not for a moment think of accepting the responsibility if I thought I would not be in a position to be helpful in any plans for

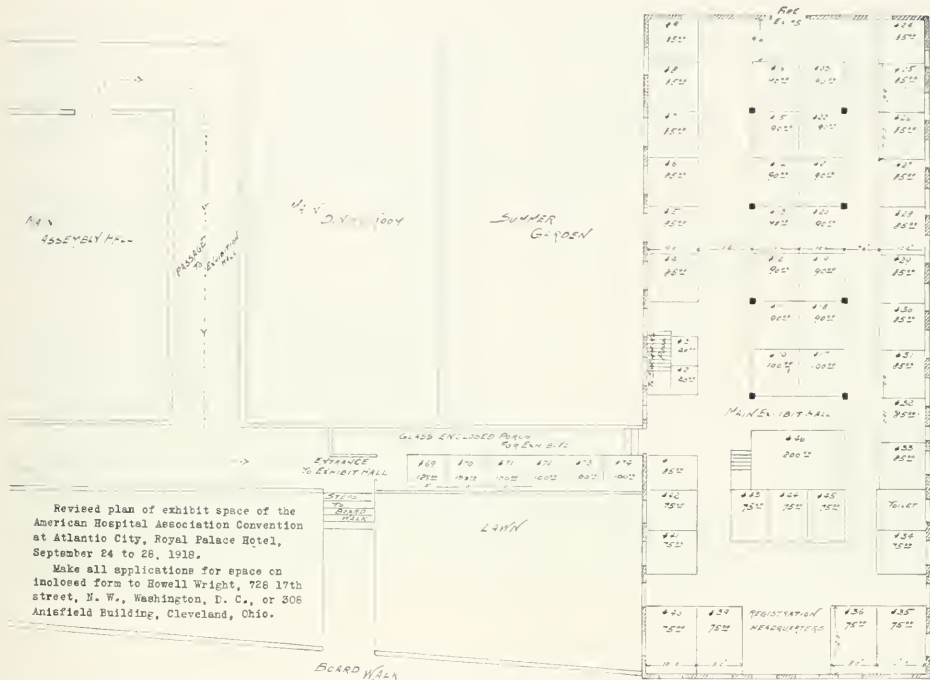


Fig. 1. Floor plan of exhibit space in the commercial exhibit of the American Hospital Association.

the present or future development of the association for greater usefulness to the country. I shall consider myself to be in such a position.

I note your statement that I am to be "the accredited executive officer of the association with all the privileges and responsibilities which usually accompany executive positions" and that "there will be no disposition to make your work difficult with unnecessary instructions or interference of any kind." I accept the position then in this spirit and in accordance with the other terms of your letter. Please accept my assurances that I will do my best for the success of an "American" Hospital Association.

Cordially yours,
HOWELL WRIGHT,
Executive Secretary.

Hotel Headquarters and Reservations

The Royal Palace Hotel is headquarters for the convention. All general sessions and section meetings, as well as the commercial and non-commercial exhibits, will be in this hotel. Reservations should be made early and application for the same should be made to the hotel direct. Neither the office of the association nor the local committee are in a position to make reservations. The following schedule of rates for accommodations, all of which are on the American plan only, will apply to delegates to the convention and their accompanying friends:

	Per day		
One person in room without private bath...	\$ 4.00	\$ 4.50	\$ 5.00
Two persons in room without private bath....	8.00	9.00	
One person in room with private bath.....	6.00	7.00	8.00
A few single rooms with private baths at...	5.00		
Two persons in room with private bath.....	10.00	11.00	12.00

A weekly rate will be given to any one desiring to remain a week or longer upon notification. Also, a suite of two rooms with bath between, twin beds in each room, for four persons might be had for \$18.00, \$20.00 and \$22.00 per day for the party.

Within a short time a complete list of other available hotels in Atlantic City, together with the rates, will be mailed to all of the members of the association; also additional literature about Atlantic City. The pre-convention number of THE MODERN HOSPITAL will contain additional information about Atlantic City, the "playground of America." The secretary has conferred with Dr. I. E. Leonard, chairman of the local committee on arrangements and Mr. W. F. Hanstein, manager of the Royal Palace Hotel. Both are enthusiastic about the convention and can be counted upon to do their part in giving members and guests a hearty welcome, and to make the convention a success. The complete membership of the local committee is as follows:

Chairman: Dr. I. E. Leonard, superintendent, Dr. Leonard's Private Sanitarium, 2842 Atlantic Avenue, Atlantic City, N. J.; Eugenia D. Ayers, R.N., superintendent, The Elizabeth General Hospital, Elizabeth, N. J.; George Bailey, Jr., superintendent, Cooper Hospital, Camden, N. J.; Mr. S. J. Barnes, financial secretary, Orange Memorial Hospital, Orange, N. J.; Nelly R. Burby, R.N., superintendent, Training School, The Paterson General Hospital, Paterson, N. J.; Miss Edith J. L. Clapp, superintendent, Englewood Hospital Association, Englewood, N. J.; Dr. S. B. English, superintendent, N. J. Sanatorium for Tuberculous Diseases, Glen Gardner, N. J.; Mrs. W. D. Harper, superintendent, Monmouth Memorial Hospital, Long Branch, N. J.; Miss Macie N. Knapp, superintendent, Overlook Hospital, Summit, N. J.; Amzi Lake, superintendent, Masonic Home, Burlington, N. J.; Miss F. Virginia Ludens, superintendent, City Hospital, Atlantic City, N. J.; Dr. John J. MacDonald, superintendent, City Hospital,



Fig. 2. Booths in the commercial exhibit.

Jersey City, N. J.; Dr. D. N. Messler, trustee, The Somerset Hospital, Somerville, N. J.; Miss Bessie L. Millman, R.N., superintendent, Orange Memorial Hospital, Orange, N. J.; Margaret T. Muller, superintendent, German Hospital, Jersey City, N. J.; Miss A. C. Murray, Presbyterian Hospital, Newark, N. J.; Miss M. Louise Pugh, superintendent, Middlesex General Hospital, New Brunswick, N. J.; Dr. Henry E. Ricketts, superintendent, Essex Co. Hospital for Contagious Diseases, Belleville, N. J.; David Schwab, superintendent, Nathan and Miriam Barnert Memorial Hospital, Paterson, N. J.; John M. Smith, superintendent, Muhlenburg Hospital, Plainfield, N. J.; Charles E. Talbot, superintendent, Newark City Hospital, Newark, N. J.

Special Trains and Transportation Rates

The following quotation from a communication under date of July 5 from the Assistant Director of the Division of Traffic, United States Railroad Administration, will answer all inquiries relative to special transportation rates to the Convention.

"The Railroad Administration has been besieged by requests of every character throughout the country for some special concessions in the matter of convention fares and, of course, it has been necessary to uniformly decline these requests. Any concession granted in one case would have to be extended to all alike, with the final result that the existing order of the director general in regard to passenger fares would be practically nullified."

The office of the association has deemed it inadvisable to attempt to make arrangements for special trains. The secretary has been informed that it is highly improbable that any such concession will be granted and therefore advises members of the association to govern themselves accordingly.

It is possible that special cars may be obtained for members from various sections providing a sufficient number of passengers can be guaranteed. For the present all inquiries relative to special cars should be made of local railroad officials. Additional information, if any can be

obtained in the meantime, will be published in the pre-convention number of *THE MODERN HOSPITAL*.

Tentative Program Twentieth Annual Convention of the American Hospital Association, Royal Palace Hotel, Atlantic City, N. J., September 24-28, 1918.

Only an outline of the program of papers and discussions can be given at this time. Particular attention is called to the division of the sessions into, first, general session, second, section meetings. No section meetings have been held before at a convention of this association.

Owing to the decision to devote Wednesday, September 25, almost entirely to discussion of hospital problems arising out of the war, it has been necessary to assign some of the section meetings to days other than those requested by the various section chairmen. It is probable that more changes will have to be made but every effort will be made to make the assignments conform to the requests.

It is planned to publish the complete program in the pre-convention number of *THE MODERN HOSPITAL*.

CONVENTION CALENDAR

Monday, September 23, 1918.

3 p. m.: Registration.

Tuesday, September 24, 1918.

9 a. m.: General session.

2 p. m.: Section meetings.

1. Out-patient.

2. Dietetics.

3. Social service.

4. Hospital construction.

Evening: Entertainment.

Wednesday, September 25, 1918.

9 a. m.: General session.

2 p. m.: General session continued.

8 p. m.: General session.

Thursday, September 26, 1918.

9 a. m.: General session.

2 p. m.: Section meetings.

1. Out-patient.
2. Nursing.
3. Social service.
4. Hospital administration.

Friday, September 27, 1918.

- 9 a. m.: General session.
 2 p. m.: Section meetings.
 1. Hospital administration.
 2. Dietetics.
 3. Hospital construction.
 4. Nursing.

8 p. m.: General session.

Saturday, September 28, 1918.

- 9 a. m.: General session.
 Reports of committees and election of officers.
 Adjournment.

TUESDAY, SEPTEMBER 24, 1918

MORNING (9 A. M.) GENERAL SESSION

Invocation—

Address of welcome—

Response—Daniel D. Test, Philadelphia.

President's address—Arthur B. Ancker, M.D., St. Paul.

Report of special committee on Institutional Membership in the association—A. R. Warner, M.D., Cleveland.

Report of the secretary, including Membership and Publicity Committee reports.

Announcements—Appointment of Committee on Time and Place.

Inspection of commercial and non-commercial exhibits.

AFTERNOON (2 P. M.) SECTION MEETINGS

Section on Out-patient Work—Michael M. Davis, Jr., Boston, chairman.
 Fighting Venereal Disease: A National Program Calling for Dispensary service. Speakers to be arranged in cooperation with the office of the Surgeon General and of the United States Public Health Service; lantern slide illustrations probably to be included.

Section on Dietetics—Lulu Graves, Chicago, chairman.
 (Meeting of American Dietetic Association), program announced later.

Section on Social Service—John E. Ransom, Chicago, chairman.

Relation of Social Service to the Successful Treatment of Gonorrhea and Syphilis in Hospitals and Dispensaries. Miss Ida M. Cannon, Boston, Chief of Social Service—Massachusetts General Hospital.
 A Social Worker at the Admission Desk—Janet Thornton, Boston, Registrar, Boston Dispensary.

WEDNESDAY, SEPTEMBER 25, 1918

MORNING (9 A. M.) GENERAL SESSION

HOSPITAL PROBLEMS RESULTING FROM THE WAR

Report of the War Service Committee—S. S. Goldwater, M.D., New York, Chairman.

Papers by representatives of Surgeon General's office, American Red Cross, War Risk Insurance Bureau, Federal Vocational Board (to be announced later).

AFTERNOON (2 P. M.)

CONTINUATION OF WAR SERVICE PROGRAM

"Utilization of Civil Hospital Facilities—Arthur W. Dunbar, Medical Director United States Navy.

Other papers to be announced later.

Inspection of exhibits.

EVENING (8 P. M.) GENERAL SESSION

Section on Nursing—

Program to be announced later.

TUESDAY, SEPTEMBER 24, 1918

AFTERNOON (2 P. M.)

Section on Hospital Construction—Dr. George O'Hanlon, New York, chairman.

(Program to be announced later.)

Inspection of exhibits.

EVENING

Entertainment by local committee.

THURSDAY, SEPTEMBER 26, 1918

MORNING (9 A. M.) GENERAL SESSION

Report of the Committee on Out-Patient Work—Michael M. Davis, Jr., Boston, chairman.

Paper on the development of War Service.

Dispensaries in France under American auspices—By a medical staff member of the American Red Cross.

Hospital Construction N. V. Perry, Constructing Engineer U. S. Public Health Service.

Report of Committee on Legislation Howell Wright, Cleveland, chairman.

AFTERNOON (2 P. M.) SECTION MEETINGS

Section on Out-Patient Work—Michael M. Davis, Jr., Boston, chairman.
 Papers and discussions on Raising Money for Dispensaries during the War; Dealing with Food Problems among Dispensary Patients; Industrial Dispensaries as part of a Program for National Efficiency during the War.

Section on Nursing—

Program to be announced later.

Section on Social Service—John E. Ransom, Chicago, chairman.

The Aims of Hospital Social Service.

Training for Medical Social Service.

Problems and Opportunities in Out-Patient Obstetrical Work or the Problem of the Cardiac.

Section on Hospital Administration—Joseph B. Howland, M.D., Boston, chairman.

Description of Clinical Record System at the Presbyterian Hospital—Adrian Lambert, M.D., Presbyterian Hospital.

Method of Keeping Payroll at the Barnes Hospital and Peter Bent Brigham Hospital—L. H. Burlingham, M.D., superintendent Barnes Hospital.

Inspection of exhibits.

FRIDAY, SEPTEMBER 27, 1918.

MORNING (9 A. M.) GENERAL SESSION

Extension of Civil Hospitals for Military Emergencies—A. B. Tipping, superintendent Touro Infirmary, La.

Discussion.

Report of the Committee on Social Insurance—Thomas Howell, M.D., New York, chairman.

Social Service and Hospital Efficiency—A. R. Warner, M.D., Cleveland. Discussion.

Report on Standardization of Hospitals—Winford H. Smith, M.D., Washington, D. C., chairman.

AFTERNOON (2 P. M.) SECTION MEETINGS

Section on Hospital Administration—Joseph B. Howland, M.D., Boston, chairman.

War Time Economies—T. A. Devan, M.D., Assistant Superintendent Peter Bent Brigham Hospital.

Other papers to be announced.

Section on Dietetics—Lulu Graves, Chicago, chairman.

Program to be announced.

Section on Hospital Construction—George O'Hanlon, M.D., New York.

Program to be announced.

Section on Nursing—

Program to be announced.

Inspection of exhibits.

EVENING (8 P. M.) GENERAL SESSION

Paper on Dietetics.

Meeting of American Dietetic Association.

Rest of program to be announced.

SATURDAY, SEPTEMBER 28, 1918

MORNING (9 A. M.) GENERAL SESSION

Report of the Treasurer—Assa S. Bacon, Chicago.

Report of Auditing Committee—W. E. Woodbury, M.D., New York, chairman.

Report, Committee on Accounting—A. R. Warner, M.D., Cleveland, chairman.

Report of Nominating Committee—Louis R. Baldwin, M.D., Minneapolis, chairman.

ADJOURNMENT

Commercial Exhibit

Members of the association are urgently requested to interest themselves in the commercial exhibit and the revised plan for the same. Included in this bulletin will be found a plan of floor space for the exhibit and an illustration of the exhibit booths which are to be erected. Members can be helpful in making the commercial exhibit a success by calling these to the attention of representatives of hospital supply houses from whom they are in the habit of buying.

A list of firms who have already engaged space and the spaces selected by them is also given below. Members are urged to keep this list at hand and to see the September

bulletin for additions. Members will be helping the association as well as themselves by patronizing these exhibitors at the convention. There are many advantages to hospital buyers placing their orders direct with the manufacturers and dealers who exhibit there. A complete revised plan with special information for commercial exhibitors is printed in this bulletin.

SPACES TAKEN TO DATE

J. S. Lippincott & Co.	18, 9
Prosperity Company	16
Prosperity Company	16
Becton, Dickinson & Co.	23
Harvey R. Pierce Company	1
The Pfandler Company	2
Wilmot Castle Company	39
Kaffee-Hag Corporation	43
Kny-Scheerer Corporation	46
Frank S. Betz Company	10, 17
Kimberly-Clark Company	45
Hospital Management	3
The Coast Products Company	32
Read Machinery Company	4
Taylor Instrument Companies	40
H. D. Dougherty & Co.	24, 25
F. A. Hall & Sons	6, 7
H. W. Baker Linen Company	11
Lewis Manufacturing Company	26
Troy Laundry Machinery Company	15
The J. B. Ford Company	14
The Holtzer-Cabot Electric Company	5
Randles Manufacturing Company	41
The Colson Company	18
Albert Pick & Co.	27, 28

Health Standards and Care for the Immigrant

In response to the nation-wide demand for better and more thorough ways of Americanizing the immigrants in the United States, the Carnegie Corporation has undertaken a national study of the methods of Americanization now in use. The work is to be done by ten divisions which are to conclude the study in a year. The division on health standards and care will be under the direction of Michael M. Davis, Jr., director of the Boston Dispensary. The aim of this particular division is to learn what the health agencies throughout the United States are doing to teach the immigrant our American standards of health. A special effort will be made to study methods which have been successful in some localities and to develop from these recommendations for communities having similar problems. The division earnestly desires the cooperation of individual physicians, and of hospitals, dispensaries, health departments, nursing and medical associations, industries, and all the national organizations working to promote the public health. Information is sought concerning health conditions and problems among the foreign-born of different races and localities and concerning methods of health care and education which various organizations have found effective among them. It is hoped that by means of this national survey material can be secured which may prove helpful to all the many individuals and groups which are striving to make the immigrant a better American citizen. It is intended to make a special inquiry into alleged serious evils due to quack practice among immigrants. This study of Americanization is one of the first large undertakings of the Carnegie Corporation, which, by the way, must not be confused with the Carnegie Foundation.

Success comes in "Cans!" Failure comes in "Can'ts!"
—Friend's Calendar.



HISTORIC MEETING OF THE ORGANIZED MEDICAL PROFESSION OF THE COUNTRY

The Sixty-ninth Annual Session of the American Medical Association—Patriotism and Reconstruction the Dominant Notes

The American Medical Association opened its sixty-ninth annual session at the Auditorium Theater in Chicago on the evening of June 11. The stirring music of the Fort Riley band sounded at the outset the patriotic tone of the whole conference. There were many scientific and clinical papers of great value at the sectional meetings during the week, and eight thousand and more men of the association attended the meeting this year. The outstanding features, however, which will live in the memories of many who attended as long as memory shall last, were the great patriotic demonstrations of the evening meetings and the papers and pictures on the reconstruction of the disabled soldier.

The opening meeting was called to order by the president of the association, Dr. Charles H. Mayo of Rochester, Minn., and welcoming addresses were made to the delegates and members by the presidents of the Illinois and Chicago medical societies. The uniformed officers of the medical reserves of the army and navy marched in military file to their seats on the stage to the music of the Fort Riley band and the cheers of the audience.

Governor Frank O. Lowden of Illinois gave a most stirring address on the necessity for each individual's sacrificing his personal interests to the winning of the war, and told of the splendid way in which the medical men of this country had responded to the call to the colors.

The representatives of Great Britain, Canada, France, and Belgium were introduced and received a royal welcome from the great audience, which stood up and applauded and cheered for each of them.

Dr. Mayo introduced Dr. Arthur Dean Bevan of Chicago, the next president, and Dr. Bevan's address, filled with the most intense patriotism and pledging the service of the medical profession of America, closed this meeting.

The section sessions on Wednesday, Thursday, and Friday were devoted to clinical papers and discussions of the sections on practice of medicine, surgery, ophthalmology, pediatrics, pathology, dermatology, stomatology, nervous and mental diseases, genito-urinary diseases, gastroenterology, and orthopedics.

The medical military meeting was held at the Medinah Temple on Wednesday evening. This meeting will go down in the annals of the American Medical Association as historic. The Medinah Temple has large seating capacity, but was packed to the doors and beyond them, and the occasion served to express the thanks of our allies to us and their faith in what America will do in the winning of the war.

The Fort Riley band, the American Choral Society, and

the voices of the audience made the rafters ring with our national songs and in tribute to the allied representatives joined in "God Save the King," the Marseillaise, and the Brabanconne.

After a brief speech by Dr. Bevan, the president of the association, Surgeon-General William C. Gorgas, U. S. Army, made the opening address. The demonstration at this meeting and whenever General Gorgas appeared at the other meetings of the association could leave no doubt as to the affection and support he has earned from the medical profession of this country.

Sir James McKenzie and Sir Arbuthnot Lane, the British representatives, men whose word is law unto the profession of medicine and surgery, were received with enthusiasm, and both gave splendid addresses in which they told of the growth of the British medical organization during the war.

M. Justin Godart, formerly undersecretary of state for the French military medical department, addressed the meeting in French, but with such clear enunciation and spirit that even those of the audience who could not understand the French wording of his speech were aroused to enthusiasm. Major Edouard Rist's address was made in most accurate English without even trace of accent. Major Rist made an apt comparison of the growth of German ideas and ruthless methods to gain world dominion, to the insidious inroads of a malignant growth in the human body. He said, "For cancer there is only one remedy, the knife, and the work must be done so thoroughly that there shall be no recurrence."

Dr. René Sand of Belgium was received with the greatest enthusiasm by the audience. Captain Sand's address was short, simple, and direct. "There are no words," he said, "which can express the gratitude of Belgium to America. You have kept us alive with food and clothing and more than that, have given us courage to live because you cared for us. The love of Belgium for America will last forever."

Admiral William C. Braisted, Surgeon-General of the Navy, expressed his enthusiasm for the men of the Great Lakes Training Station, and his belief in our ultimate victory which shows in the faces of the 30,000 jacksies out there.

President Ray Lyman Wilbur of Leland Stanford University, addressed the meeting for the Food Administration and Major Alexander Lambert, M. R. C., told of the American Red Cross work in France.

All day Thursday at the Auditorium Theater was given over to the subject of reconstruction. To these meetings the general public were invited. It is the purpose of the government and the office of the Surgeon-General to prepare the public mind for this work which will have to be done and to gain their intelligent cooperation.

At the morning meeting, General Gorgas, Lieut.-Col. Frank Billings, Lieut. Casey Wood and others explained something of the purpose of the government in the building of reconstruction hospitals and the reclaiming and reeducation of war cripples.

The afternoon meeting was devoted to reconstruction and vocational education. Mr. F. B. Kidner of the Department of Soldiers Civil Reestablishment in Canada told of the work done in placement and occupations for the disabled there.

Mr. Douglas McMurtrie of the Red Cross Institute for Crippled and Disabled Men of New York City, who has been on the other side studying the methods used by the allies in reconstruction, illustrated his talk with moving pictures showing the school and workshops at Montpellier, France, where great numbers of the disabled from the

French army are fitted with various prosthetic appliances and taught to walk and to work again.

The following officers of the American Medical Association were elected for the coming year: president-elect, Alexander Lambert, New York City; first vice president, William M. Wishard, Indianapolis, Ind.; second vice-president, E. Starr Judd, Rochester, Minn.; third vice-president, C. W. Richardson, Washington, D. C.; fourth vice-president, John M. Baldy, Philadelphia, Penn.; secretary, Alexander R. Craig, Chicago; treasurer, William Allen Pusey, Chicago.

* * *

HOSPITAL ADMINISTRATION FROM THE MEDICAL POINT OF VIEW

The Massachusetts Medical Society at Its One Hundred and Thirty-Seventh Annual Meeting Discusses Hospital Standardization

The exercises of the one hundred and thirty-seventh anniversary of the Massachusetts Medical Society were held on June 18 and 19, 1918. Of especial interest to hospital executives were the afternoon sessions. The June 18 afternoon session was devoted to a symposium on the Massachusetts Plan for Caring for Consumptives, with Dr. Walter G. Phippen, of Salem, Mass., in the chair, and Dr. John B. Hawes, 2nd, of Boston, acting secretary. The afternoon session of the 19th was devoted to the question of hospital administration. Dr. Homer Gage, of Worcester, acted as chairman, and Dr. Channing C. Simmons, of Boston, as secretary.

In the symposium on the Massachusetts Plan for Caring for Consumptives, Dr. Arthur K. Stone, of Framingham Centre, chairman of the Board of Trustees of the Massachusetts Hospital for Consumptives, read a paper on "The State Tuberculosis Sanatoria and What They Aim to Do." The purpose of the state tuberculosis sanatoriums, he said, was to recover health by curing, and to stimulate effort to overcome preventable disease. During recent years Massachusetts has had four commissions at work, studying the problem of tuberculosis within the state, and as a result various sanatoriums have been built. The state now has 1,065 beds. The sanatoriums, however, instead of devoting themselves to their legitimate purpose, namely, the curing of curable tuberculosis cases, are forced to accept cases that need to be segregated for the protection of the public; for instance, at the North Reading Sanatorium there are nearly one hundred bed cases which should be in hospitals. Dr. Stone contended that it was perfectly safe for most of the patients discharged from the sanatoriums to spend eight or nine hours in ordinary work in the mills. It was the way in which patients spent the remaining sixteen hours of the twenty-four that made the difference between health and sickness. He contended that the sick should be taken care of near their homes, and that municipal and county institutions should be reserved for the care of advanced cases. Closer cooperation could be effected between the state sanatoriums and the county and municipal hospitals through conference. He felt that the dispensary system should be especially developed to supervise discharged cases and arrange for their readmission when necessary.

Dr. Olin F. Pettingill, superintendent of the Essex County Sanatorium, read a paper on "County Tuberculosis Hospitals." The county tuberculosis hospitals at present provide beds for curable cases and also take care of advanced cases. The two classes, in Dr. Pettingill's judgment, should not be treated in the same institution. He felt that the county sanatoriums should be centers for

advice and diagnosis, and that all patients should be admitted with the privilege of transfer.

Dr. Edwin A. Locke, chief of staff of the Boston Consumptives Hospital, read a paper on "Local Municipal Tuberculosis Hospitals." Most patients suffering from tuberculosis, he said, have been infected in early life by direct contact. The keynote of all tuberculosis work, therefore, should be prophylaxis. In the campaign against the disease, state and federal governments should exercise a supervisory function, while the direct attack should be left to the individual communities. Preventive measures should especially aim to avoid infection to childhood, since implantation usually takes place during that period. These measures should aim to increase the resistance of the child and to segregate the active cases. The institutional care of advanced cases was, in his judgment, the outstanding factor of treatment. Many patients should be sent to sanatoriums, although some might remain in their homes under the supervision of tuberculosis dispensaries. The incorrigible, however, should be segregated, and institutional care should be provided for the destitute tuberculous. Sanatoriums should be accessible to the patients and should suggest the hope of cure by being free from advanced cases. Dr. Locke devoted the latter part of his paper to a discussion of the size, cost, and type of building, and equipment of municipal hospitals.

In his paper on "The Dispensary System of Follow-up Work," Dr. John F. Hitchcock, Northampton, director of the division of communicable diseases, State Department of Health, divided tuberculosis patients into three groups: (1) open cases; (2) incipient cases; (3) exposed but not yet infected cases. The latter two are not a danger to the public. The first group should be cared for in hospitals; the second in sanatoriums; and the third in dispensaries. Last year, he said, there were fifty-three dispensaries in Massachusetts, employing one hundred and two physicians, sixty-four nurses on full time and thirty on part time, as well as six social workers. The dispensaries had been in touch with 21,689 persons, or 409 to each dispensary. Of this number 55 percent were tuberculous, or suspected of tuberculosis, while 45 percent were not tuberculous.

In the session on hospital standardization Dr. John T. Bottomley, Boston, read a paper on "Hospital Standardization—What It Means." Dr. Bottomley felt confident that the cooperation of the hospitals could be secured in the present movement for hospital standardization, if the motives of the American College of Surgeons in seeking standardization were thoroughly understood. Since patients in hospitals have a right to efficient treatment, the primary purpose of standardization was the patient's wellbeing. Other desiderata may follow, but this is primary. Every hospital should be so manned, equipped, and administered as to bring the highest possible percentage of the best medical skill in each community to the needs of the patients. To Dr. Bottomley, the standards of hospitals means the standards of the medical profession serving them, and any reform in hospital practice must come from the physicians and surgeons themselves. He pointed out that the process of standardization must be a gradual one, in which hospitals that are doing bad work must be helped to do good work, and hospitals that are doing good work must be urged to do even better work. The requirements will be placed low at the beginning in order to enable hospitals generally to secure a rating of at least 90 percent with reasonable diligence. Among the essential requirements are (1) a sufficient record of the patient; (2) sufficient laboratory space and equipment for ordi-

nary examinations; (3) establishment of some supervision over the medical work in the hospital, as, for example, through a small committee of staff members.

In discussing the method by which standardization would be brought about, Dr. Bottomley said that a representative of the American College of Surgeons would visit the board of trustees of each hospital and make an inspection of the hospital in a kindly, friendly, tolerant way and later submit suggestions and recommendations looking to the improvement of plant, equipment, or service. Six or eight months later another visit would be paid to see whether the suggestions and recommendations had been carried out. Hospitals, as the result of these examinations, were not to be classified as A, B, C, etc., but would be known as meeting or not meeting the standards established.

In discussing this paper, Dr. Huff, of the New Bedford Hospital, New Bedford, Mass., stated that it was almost impossible to get interns to keep proper records and that they could not be compelled to do so. He felt, however, that if the chief of the service inspected records, they would be kept better.

"The Administration of a Military Base Hospital and Its Comparison with a Civil Hospital" was the subject of an address by Lieutenant-Colonel Channing Frothingham, M.C., N.A. A base hospital must be prepared to take care of any kind of medical or surgical case (except, of course, women's and children's diseases and chronic ailments) and the best treatment must be furnished, as the patients cannot be sent elsewhere.

The medical department provides the hospital and its officers. Light, heat, and water are furnished the commanding officer by the ordnance department. Supplies come from three sources: the medical department, the quartermaster's department, and the ordnance department.

The officers are divided into two main groups: those who need medical instruction and those who do not. The sanitary corps, for example, contains many men who are not medical workers, but who do executive work and thus liberate medical men for purely medical work. The adjutant, who is the commanding officer's private secretary, need not be a medical man. The registrar is the librarian and takes charge of the records of the patients. One officer sees to the feeding of the patients and enlisted men. The medical property officer by requisition gets property for the chiefs of the various departments. The chaplain arranges for the religious services and provides for the social welfare of the men. The officer of the day serves for twenty-four hours as personal representative of the hospital and has charge of the guard.

The professional staff is divided into three main divisions—medical, surgical, and laboratory, the chiefs of which form a council or "board of strategy." The specialties are brought together under the chiefs and in many instances there are assistant chiefs of service. The ward physicians and surgeons take the histories of the patients, prescribe, and have general charge of the patients in the wards. The receiving officer is held responsible for the reception and discharge of patients. The sanitary officer acts as sanitary inspector and sees that the buildings and grounds are kept in good sanitary condition. The convalescent officer has charge of the patients who are well along toward recovery and looks after them until they are ready to go back into service.

Colonel Frothingham expressed the need of a training school for military nurses, and announced that one was

to be established shortly at Camp Devans, where he is stationed, and at several other camps.

Things get done more readily in the base hospital than in the civil hospital. The officer has but to command and the command is obeyed forthwith. Little money is seen, as everything but food is secured on requisition. The ration money is the only money which comes over the desk.

The men on service in the base hospital are whole-time men. It is thus possible to concentrate a group of medical men on a single case at any time for diagnosis and treatment. While serving in a base hospital you may be forgiven for lack of judgment but not for failure to use the opportunities which the hospital affords. The base hospital gives the medical men the opportunity to follow up their treatment as long as they want to. This is especially desirable in venereal work.

Dr. E. H. Bradford, Boston, read a paper on "The Need of Systematic Teaching of Hospital Interns." In many states, Dr. Bradford pointed out, physicians must have a hospital year before they are allowed to practice. The American Medical Association has remedied the old proprietary school situation, and a number of the medical schools now educate their men well, but they lack the practical training of apprentices. Science has advanced so rapidly that practical experience cannot be gained in the medical school. The hospitals have taken advantage of the condition of the market and forced interns to take long-term service. Some have even been compelled to wait six months while they served as clerks in the hospital. They do not receive an adequate education, because the hospital authorities use them instead of teaching them. How is this situation to be remedied? Hospitals must demand of the chiefs of services that they instruct their interns; boards of trustees must demand that the administrative heads of the hospital see that interns are instructed; medical schools must demand that interns be instructed in hospitals; and medical societies must demand that hospitals educate their interns. The education of the intern is part of the standardization of hospitals. Interns must learn by training their own powers of observation and assuming definite responsibilities. There should be regular meetings of the staff and interns to discuss cases.

Dr. Richard M. Smith, Boston, gave an address on "Social Service and Follow-up Work." The changed attitude on the part of hospitals toward social service work is becoming increasingly marked. Hospitals are realizing more and more that they cannot confine their diagnosis to the patient as he presents himself at the hospital, but must consider his living and working conditions. The hospital cannot limit itself to purely medical problems, but must consider the causes of disease and interest itself in the prevention of disease.

The physician in the hospital cannot make the necessary social investigation and consequently sees the patient out of his natural environment unless his observations are supplemented by the knowledge which the social worker through her study of home and working conditions brings. The advantage to the patient of the social worker is that she makes the relation of the patient to the hospital less rigid.

The success of hospital social service, Dr. Smith pointed out, depends on accurate medical work, including an accurate diagnosis and a definite line of treatment. Hospital efficiency is decreased if it fails to take into consideration the background of the patient more than if it lacks certain equipment.

Some of the functions of the hospital social worker are: to arrange for the discharge of patients from wards to other institutions; to see that treatment is carried out exactly as the doctor orders; to see that patients keep appointments to come into the hospital; and to arrange for subsequent appointments in the out-patient department. The development of social service work should be with the closest cooperation and supervision of the medical men and only trained people should undertake the work as the hospital social service field must be recognized as a special field requiring careful training and experience.

In discussing Dr. Smith's paper Mr. Michael M. Davis, Jr., said that a misconception of the function of social service work in hospitals on the part of physicians had interfered with its development. Its function is a medical one, intended to help maintain medical efficiency. One of the seemingly great obstacles to the introduction of social service in many hospitals is its cost, and yet money is wasted by many hospitals through sheer lack of social service workers. Mr. Davis felt that in appealing to the public for funds to support social service work in hospitals, stress should be laid not only on the humanitarian motive but also on the efficiency motive, since only through competent social service work can the most efficient medical service be rendered the community.

* * * *

RECONSTRUCTION FROM WAR AND FROM INDUSTRY

The Third Annual Meeting of the American Association of Industrial Physicians and Surgeons—Plans for Effectual Cooperation with Government for Reconstruction

The American Association of Industrial Physicians and Surgeons met in the Florentine Room of the Congress Hotel in Chicago, June 10. The meeting was to consider industrial conditions and problems brought about by the war and ways and means by which the members of the association, men skilled and experienced in emergency surgery and the health protection of labor, could help to speed the war and to win the war.

Dr. C. D. Selby of Toledo, Ohio, gave the following interesting summary of war-time industrial problems:

It has been estimated that it takes the labor of six and one-half persons to furnish material and supplies for each fighting man. This will make, in time, approximately 32,000,000 persons in our industrial forces. It has become a national duty to protect the efficiency of these forces from the shortage caused by illness or accident in order to facilitate and speed production. The coordination of man and woman power to replace shortage, the necessity of physical examination and health protection for all employees, betterment of conditions to prevent migratory labor, and more counsel between employees and representatives of industrial medicine, were well suggested by Dr. Selby as aid in conservation of labor in war industries. The suggestion was also made that an industrial service corps to take the responsibility for the conservation of industrial man power in making war supplies could give good service to the government in the present crisis.

Lieut.-Col. Harry E. Mock, who is an assistant director of reconstruction in the Surgeon-General's Office, read an interesting paper on the reconstruction of the returned disabled soldier in the industries, and predicted government supervision of industrial health welfare. During the discussion of this paper some interesting points were

brought up on the educational value of the Red Cross nursing service in industrial health conservation, and in agricultural industry. It was also mentioned in the discussion that Harvard University was planning to enlarge its medical school to include a chair of industrial surgery.

Mr. T. B. Kidner, the vocational secretary of the Invalidated Soldiers' Commission of Canada, told how the Dominion was caring for 30,000 returned men, through the splendid cooperation of medical men, employers and vocational educators, and how each man was provided with something definite to do. The men in Canada are returned to a place near their homes or the spot from which they enlisted. Each is first given a vacation to visit relatives and friends and then returned to the nearest curative shops for further training in his old trade or occupation if possible, and if not, in some other which will provide him with a means of living. When this has gone far enough, the employment branches in each province provide the employment. The returned soldier is paid from the time he enters the curative shop and is free from the worry of earning enough to maintain his family. Each returned soldier is carefully studied to learn his limitations and his possibilities, and since the Canadian commission has become more efficient in its management of the reconstruction problem, a sufficient variety of vocational training is provided to care for every type of the handicapped. It is encouraging to report that, according to the statistics furnished by Mr. Kidner, the percentage of mutilated men who have suffered major amputations is comparatively small, and that there are very few blind in proportion to the number of men involved.

Captain Sand of the Belgian army was introduced as one from that brave little country which has stood between us and the Hun for so long and the audience arose with one impulse to pay tribute to him. Captain Sand told, without spleen and without raising his voice from the ordinary narrative tone, of the deportation of 120,000 Belgian men from the industries to work in slavery, of the seizure of all available raw material, machinery and funds, and of the mission of seven veterans, of whom he was one, to learn all that they could here to reconstruct their country when their barbarous conquerors shall have been driven out of Belgium.

Lieut-Col. James Bordley's paper on "Reclaiming the Blind from War and from Industry" was illustrated with motion pictures, showing the work accomplished with the blind in various trades.

Dr. Francis D. Patterson, chief of the division of industrial hygiene and engineering of the Department of Labor and Industry, Pennsylvania, gave something of the plans in that state to arrange for the cooperation of the industrial plants with the commission in the rehabilitation of the disabled soldier.

A banquet was given at the hotel in the evening and Mr. Douglas C. McMurtrie, of the American Red Cross Institute for Cripples, gave a summary of the reconstruction work being done abroad. This was illustrated with moving pictures showing the reeducation of the handicapped in France and England.

The following officers of the American Association of Industrial Physicians and Surgeons were elected for the coming year: president, Lieut.-Col. Harry E. Mock, assistant director of the division of reconstruction in the office of the Surgeon-General of the Army; vice-president, Dr. Thomas E. Crowder, medical director of the Pullman Company; second vice-president, Dr. Otto P. Geier, medical director of the Cincinnati Milling Company; secretary and

treasurer, Dr. Francis D. Patterson, chief of the division of industrial hygiene and engineering, Department of Labor and Industry of Pennsylvania.

* * * *

MINNESOTA HOSPITALS HOLD A SUCCESSFUL MEETING

Interesting and Patriotic Program at First Annual Conference of Minnesota Hospital Association

The first annual conference of the Minnesota Hospital Association was held in Minneapolis, June 27 and 28. The association was organized April 20, 1917, upon the initiative of the Minneapolis Hospital Council, a local organization of hospital superintendents. The membership had increased during the year from forty-eight to sixty, representing fifty hospitals in the state.

A program providing for six sessions during the two days of the meeting had been prepared by the executive committee, composed of Mr. G. W. Olson, superintendent of the Swedish Hospital, Minneapolis, president of the association; Mrs. George G. Eitel, superintendent of the Eitel Hospital, secretary-treasurer of the association; Miss Harriett Hartry, superintendent of St. Barnabas Hospital, Minneapolis; Rev. Henry Hartig, superintendent of St. Andrews Hospital, Minneapolis; and Dr. S. G. Cobb, surgeon-in-chief of Cobb Hospital, St. Paul.

A prayer was offered by Rev. William Meyer, superintendent of the Deaconess Hospital, Faribault. The address of welcome on behalf of the city was delivered by Prof. A. J. Todd, Ph.D., head of the department of sociology of the University of Minnesota, who is also president of the Central Council of Social Agencies of the city of Minneapolis, an organization with which all the hospitals in the city are affiliated.

Mr. Olson, the president of the association, in the course of his annual address, said:

"Within our own state hospital progress during the past year may be said to have been normal. New construction has been merely nominal, however, and has not kept pace with the need of the increasing population in many centers. But there will be notable additions to our hospital facilities in the near future. Through private benefactions a new large general hospital will soon be built in St. Paul. The city of Duluth has received a bequest of \$600,000 for the founding of a new general hospital. St. Mary's Hospital in Minneapolis is completing and will soon open a new building, the largest in the state devoted to the care of private patients. Construction of a new modern building for the Lymanhurst children's annex of the Minneapolis City Hospital has been begun, but cannot be completed until the next legislature has authorized the city to issue further bonds for the completion of the structure.

"A few small private hospitals have been discontinued during the year. Others have been transformed from private enterprises into community institutions, by transfer of ownership and control from individuals, usually, physicians, to groups of citizens organized into hospital associations. These conversions of the village surgeons' individual enterprises into community hospitals, with ownership and responsibility in the hands of the best citizens of the town, are good signs of a better understanding of the functions of the hospital on the part of both profession and laity throughout the state. It were desirable if more of the small private so-called hospitals could be turned into community enterprises, serving all the qualified physicians and the whole public within the county or whatever unit might be adopted as the community to be served. The nursing problems of this type of hospital is the great retarding factor in its development. It is now much easier for the individual surgeon to conduct a private hospital of a few beds in a private dwelling, where the care can be administered by a practical nurse, than to operate a central hospital open to other physicians and

to all the people, because in such a plant there must be a larger number of persons engaged, with a higher standard of system, organization and discipline.

"Minnesota presents conditions favorable for the development of the ideal small community hospital. I believe it would be possible in this state, through a little effort on the part of our association, to secure legislation whereby hospitals could be aided by their respective communities with appropriations from public funds, eligibility to receive such aid to be determined by a state hospital inspector functioning under the state board of health. The hospital could then be made the center of public and private health activities in the community to which it belongs. Surely, it should be no more difficult to legalize the appropriation of town funds toward the support of a hospital than to a fire hose company, a town brass band, or a base ball park and team of players."

In preparing the program, the committee aimed to give prominence by precedence to "win the war" topic. "Food Conservation in the Hospital" was presented by Mrs. Beth B. Titus, chief dietitian of the Minneapolis City Hospital. Discussion showed unanimous desire that the government fix the prices of the wheat substitute cereals.

"Wartime Economies in the Hospital" was the subject of a very instructive talk by Dr. A. B. Ancker, superintendent of the City and County Hospital, St. Paul, and president of the American Hospital Association, who said:

"Hospitals are exempted from all of the restrictions of the federal food administration, but there is no valid reason why they should not observe every one of them. Hospital officials, nurses, and employees are as capable of 'Hooverizing' as any other class of workers. The same is true of patients on house diet. Patients on restricted diet have always been 'Hooverizing.'"

"Some years ago I came near accepting the superintendency of an eastern hospital. One of the conditions I insisted upon was that no purchases were to be made without my order or approval. In discussing this question with the governing board, I found that they had entered into a contract for the purchase and delivery of five thousand dollars' worth of gauze in one year. In our hospital in St. Paul we bought five hundred dollars' worth for the same period for about the same number of patients. I didn't go East, because I could never stand to see money squandered that way."

The second session of the conference opened with a program dealing with the various phases of the nursing problem in the small, medium-size and larger hospitals in the state. "The Small Hospital Without a Training School," was the subject of a paper by Miss Lillie Denning, R.N., superintendent of the community hospital at Benton. Miss Georgia H. Riley, R.N., superintendent of the Montevideo Hospital, read a paper on "Can the Small Hospital Maintain a Training School?" Miss Louise M. Powell, R.N., acting superintendent of the University Hospital, Minneapolis, presented a paper on "The Training of Pupil Nurses from Affiliated Schools." The papers and the discussion following emphasized the fact that to train nurses properly it is necessary to have not only qualified teachers and pupils, but most important of all, a sufficient variety of clinical material and adequate teaching equipment. The first two requisites are not difficult to provide in this state, where capable instructors and supervisors and a high grade of student nurses may be obtained by any hospital offering reasonable pay and accommodations. The clinical material and teaching equipment, however, are sadly lacking in many of the small hospitals. Reorganization of these hospitals on a broader plan, development of community interest in what is now private enterprise and making of the small hospital a social and educational factor would result in support and patronage that would place the hospital in position to conduct an accredited training school with affiliation.

The Thursday evening session was devoted to a round-table discussion of questions touching the details of hospital management. Prof. A. D. Wilson, federal food administrator for Minnesota, gave an inspirational talk on "Food Conservation in Institutions." Dr. Herbert O. Collins, superintendent of the Minneapolis City Hospital, presided over the round-table conference at which the following questions were discussed:

1. Should the training schools in Minnesota adopt immediately the policy of giving credit, by shortening the three-year course, to college graduates?

2. Would it be good business practice to separate the training school from the hospital as far as accounting and cost of maintenance is concerned? Would the result of such separation provide the answer to the oft-repeated charge that the hospitals are getting the nursing done for little or nothing?

3. Is the present method of taking the patient census, to arrive at the daily average number of patients, as prescribed by the Minnesota State Board of Examiners of Nurses, the correct one?

4. What are the advantages of a central linen room in the hospital and what is the best plan of operation?

5. What is the simplest, most efficient and economical way to disinfect a room after an infected case?

6. How can the hospital protect itself against losses on workmen's compensation cases where the hospital charges exceed the statutory allowance?

7. What is the best method of collecting delinquent hospital bills?

8. What is the remedy for the present shortage and high prices of hospital linens, blankets and bedding?

A paper on "The Design and Construction of the Smaller Sanatorium and Hospital" was read by Mr. E. H. Sund, architect, Minneapolis, who has designed a number of small surgical hospitals and several of the state-county tuberculosis sanatoriums built recently. In the discussion Dr. H. O. Collins brought out the fact that, with all the excellence of design and construction put into the modern hospital, whether small or large, the builders too often forget to provide accommodations for those who must carry on the work in these institutions and who must necessarily live with their work day in and day out in order to maintain satisfactory service to the sick. Dr. Robinson Bosworth, St. Paul, executive secretary of the Advisory Commission for Tuberculosis Sanatoria in the state, said that the building of modern sanatoriums had resulted in a greater number of consumptives submitting to sanatorium treatment than ever before and for a longer period of time, and that a reduction in the death rate from tuberculosis within the state could already be traced to the operation of these sanatoriums. Dr. Bosworth's address was discussed by Dr. E. S. Mariette, resident physician at Glen Lake Sanatorium, Hennepin County, and Dr. Conroy, of the Nopeming Sanatorium, St. Louis County. "The Value of Standardization of Hospitals in Smaller Communities in Minnesota" was the subject of an address by Dr. J. W. Andrews, Mankato, which was discussed by Dr. Arthur T. Mann, associate professor of surgery at the University of Minnesota. "Hospital Business Record-Keeping" was discussed in a paper by Mr. J. E. Haugen, superintendent of the St. Paul General Hospital, who outlined a system in use in his institution which had proved satisfactory as to the amount and variety of detail necessary and desirable in hospital accounting and yet been found economical in operation.

On Friday afternoon a paper on "The Hospitals and the Law—Extent of Privileges and Protection Granted to General Hospitals by the Laws of Minnesota" was read by Mr. George S. Grimes, attorney and member of the board of trustees of St. Barnabas Hospital, Minneapolis, who through years of experience as a hospital trustee had become familiar with the legal phases of hospital work and worked out solutions of many knotty problems. The final

paper of the comprehensive program was "Mechanical Equipment and Fuel Economics," by Mr. R. B. Whitacre, St. Paul, an old experienced power-plant engineer. This paper brought out in detail many points relating to heating, ventilation, steam and hot-water production, etc., which are too often not given due consideration until mistakes have been made that require costly alterations.

All present were invited to join in an automobile tour about the city. Automobiles had been provided gratuitously through a committee of the Minneapolis Hospital Council, headed by Miss Bertha Matlick, superintendent of Hill Crest Hospital. The tour provided a view of practically every hospital in the city, gave opportunity for inspection of the new building of St. Mary's Hospital, and ended with a delicious picnic lunch served by dietitians of Minneapolis hospitals at the charming summer home of Miss Harriett Hartry, superintendent of St. Barnabas Hospital.

The following officers of the association were elected for the ensuing year: president, Dr. Herbert O. Collins, City Hospital, Minneapolis; first vice-president, Dr. E. S. Mariette, Glen Lake Sanatorium; second vice-president, Mr. Fred Paulson, Norwegian Lutheran Deaconess Hospital, Minneapolis; third vice-president, Mrs. Sarah H. Knight, Asbury Hospital, Minneapolis; secretary-treasurer, Miss Lydia H. Keller, secretary of the State Board of Examiners of Nurses, St. Paul; members of executive committee, Dr. A. T. Laird, Nopeming Sanatorium, Duluth; Miss A. Jeanette Christianson, Northwestern Hospital, Minneapolis; Miss Louise M. Powell, University Hospital, Minneapolis.

* * * *

FIRST CONVENTION OF HOSPITALS OF BRITISH COLUMBIA

Successful Meeting Held and Interesting Program Presented at Meeting in Vancouver

The first convention of hospitals ever called together in the province of British Columbia was held at Vancouver, June 26-28, 1918. It was planned for the benefit of every person connected directly with or interested in hospital work of any kind, no matter how small or how large the institution represented. After prayer by Major the Rev. C. C. Owen, address of welcome by his worship Mayor Gale and Dr. C. H. Gatewood, chairman of the board of directors of Vancouver General Hospital, papers were read on the following subjects: "Hospital Standardization," by Dr. R. E. McKechnie, F.A.C.S., member of consulting staff, Vancouver General Hospital; "The Hospital; Past, Present, Future," by Dr. A. S. Munro, member of the board of directors, Vancouver General Hospital; "The X-Ray Department," by Dr. W. A. Whitelaw, radiographer to the Vancouver General Hospital; "Problems of the Hospital in Outlying Districts," by Dr. W. R. Wrinch, superintendent Hazelton General Hospital; "Small Economies in Hospitals," by Miss J. F. MacKenzie, R.N., lady superintendent of the Provincial Jubilee Hospital, Victoria, B. C.; "Hospital Architecture," by Mr. J. A. Benzie, architect, Vancouver, B. C.; "Standardization of Hospital Equipment and Supplies," by Mr. R. B. Leders, purchasing agent for the Vancouver General Hospital; "The Hospital as a Community Service," by Dr. H. E. Young, secretary Provincial Board of Health; "The Elimination of Chronic Hospital Cases by Proper Dental Diagnosis and Treatment," by Dr. Milton Jones, Vancouver, B. C.; "Financing the Hospital," by Mr. M. L. Grimmer, member of the board of directors, Merritt Hospital; "Hospital Account-

ing," by Mr. Geo. S. Haddon, managing secretary the Vancouver General Hospital; "The Hospital Laboratory," by Dr. R. H. Mullin, director of Laboratories, Vancouver General Hospital; "The Food Problem of Today as It Affects the Hospital," by Miss G. Sinclair, superintendent of the Royal Columbian Hospital, New Westminster; "The Hospital Dietary," by Miss E. Kinney, dietitian to the Vancouver General Hospital; "The Assistance of Publicity to the Hospital," by Mr. R. S. Sommerville, member of the board of directors, Vancouver General Hospital; "Maternity Work in the Small Hospital," by Dr. W. B. Burnett, obstetrician to the Vancouver General Hospital; "The Hospital Pharmacy," by Mr. E. Hall, pharmacist to the Vancouver General Hospital.

Round-table conferences were conducted by Miss G. N. Sinclair, superintendent of Royal Columbian Hospital, New Westminster, B. C., Miss J. F. MacKenzie, superintendent of nurses, Provincial Jubilee Hospital, Victoria, B. C., Miss K. Campbell, superintendent of Cumberland Hospital, and Miss M. P. MacMillan, superintendent of Nanaimo Hospital. The exercises closed with a motor ride and visit to Royal Columbian Hospital, Westminster, and provincial mental hospitals, and convocation of nurses at Vancouver General Hospital. Many of these papers will appear in future issues of THE MODERN HOSPITAL.

Nearly one hundred delegates, representing as many hospitals, were present, and the keenest enthusiasm was manifested. Enjoyable entertainments were provided. The convention ended with the adoption of constitution and by-laws and the election of the following officers: honorary president, Hon. Dr. J. W. McLean; president, Dr. M. T. McEachern; first vice-president, Mr. R. S. Day, Victoria; second vice-president, Mayor Gray, New Westminster; secretary, Mrs. M. E. Johnson, Vancouver; treasurer, Dr. C. H. Gatewood, Vancouver; executive committee, Dr. F. X. McPhillips, Vancouver; Miss M. McMillan, Nanaimo; Charles Graham, Cumberland; Miss L. S. Gray, Chilliwack; Miss Pitblado, Kamloops; M. L. Grommett, Merritt; D. G. Stewart, Prince Rupert; Dr. H. C. Wrinch, Hazelton; Miss B. E. Langley, Fernie; Miss H. Campbell, Vernon.

* * * *

Officers of Conference of Tuberculosis Secretaries

At the Fifth Annual Conference of Tuberculosis Secretaries, which was held in conjunction with the Fourteenth Annual Meeting of the National Tuberculosis Association, reported in the July issue, p. 46, the following officers were elected: president, Robert Patterson, Ohio State Tuberculosis Association, Columbus, Ohio; vice-president, Ernest J. Easton, New Jersey Tuberculosis Association, Newark, N. J.; secretary and treasurer, Edward Hochhauser, Committee for the Care of the Jewish Tubercular. Mrs. Sadie Orr-Bunbar, secretary of the Oregon Association for the Prevention of Tuberculosis, Portland, Ore., and Mr. Dwight Breed, secretary of the Texas Anti-Tuberculosis Association, Austin, Tex., were elected members of the executive committee.

The Touchstone Magazine, of New York City, has announced that plans are under way for the establishment of a convalescent club for soldiers at Lake Worth, near Palm Beach, Fla. The buildings will include a central clubhouse, cottages to house from one to six men, and laboratories; and a dairy and gardens will be maintained in connection with the colony. Dr. A. Thompson Downs, of Saratoga, will head the medical staff.

THE MEMOIRS OF A HEAD NURSE

III. St. Patty of the Hospital by the River—A Gentle Soul Who Has Kept Her Usefulness and Her Faith Through Years of Blindness.

One would hardly expect to find a saint, really alive and sitting straight and brave in an old-fashioned rocking chair in a little room, but I know of one hospital which can boast of such a shrine.

Down in an Iowa hospital, where from the windows you can see a wonderful view of the Mississippi above and below, Aunt Patty sits in her old-fashioned high-backed rocker. She knows the river well, has known it for eighty-three years, but has not seen it for many a day—the river or anything else—because she has been entirely blind for a long time. She is crippled as well as blind; she walks only with the aid of a big stout cane; her hands are twisted like the roots of a very old tree. No two of her fingers are parallel, but she makes most of her own clothes, hems towels and napkins for the hospital, keeps herself immaculate, her room in perfect order, and never asks the nurses to do anything for her that she can possibly do for herself. Every fold of the linen on her bed is as straight as though it were drawn with a draughtsman's T and square. In the drawers of her bureau are even little piles of clothing, handkerchiefs and ribbons and picture post cards, just where a touch can find them. The dresses which she wears and which she makes for herself are always black because she is the last of her family of twelve brothers and sisters, and it is part of Aunt Patty's code of honor always to wear it for them. How she can make these dresses is a mystery to all of us who have watched her. They are made of black sateen in winter and of thinner cotton goods in summer. The waists have high collars and box plaits coming down from the shoulders, and every plait is accurate and like every other plait.

I visited Aunt Patty not long ago. When I have told you something of her philosophy and viewpoint of life, I think that you will say I am not far wrong in calling her little room the shrine of a saint. I had known this dear old lady several years before, and the day before I arrived the nurses had told her that I was coming, so the room was very tidy and Aunt Patty was waiting. She sat as usual, straight in her rocking chair, on the washstand beside her the bouquet of sweet peas and mignonette I had sent from the florists earlier in the day. Sensitive to changes of atmosphere as all blind people are, she had carried the flowers from one place to another in the room, as the sun changed, to keep them cool and fresh. Later she told me that she was going to press some of them in her Bible.

The superintendent of the hospital had escorted me to her room, and, as we stood in the doorway, she said, "Here is someone to see you, Mrs. Hillhouse!"

Aunt Patty stretched out both arms and answered, "I know who it is."

When I went over to her she drew my head down to her own and felt my face with her hands, saying again, "Oh, my dear, I knew you would not forget me, and you look just the same, just the same."

Then, Aunt Patty keeping tight hold of my hand, I sat down beside her, knowing well that in that half hour that I had to stay I should surely get courage and comfort and understanding to take away with me.

"How is it with you?" I asked, and she answered:

"Very well, my dear. The Lord is good. I am not yet a burden to these good people who are so kind to me. I

am just sitting here and waiting. My nephew, who has gone to the war and I am the last; all the rest are gone. Every night when I lay my head on the pillow, I say, 'Lord, thou hast helped me to live through another day; give me strength for tomorrow, and if it is thy will to end my time, let me go tonight while I sleep, that I may not at least be a care to others and a misery to myself,' and then I sleep well until morning.

"I had a dream the other night. I told it to the minister and he said it was a beautiful dream and that he would make a sermon out of it for his congregation. I thought I was standing on the shore of the sea. Although my eyes were still blind, I knew that the place was beautiful. Back of me I could hear the wind in the trees. I knew that there was sunlight, and not far below me I could hear the wash of the waves as they broke on the beach. A voice called me by name, and said, 'On this shore is a wonderful pearl. If you can find it and hold it in your hand, your eyes will be opened and you shall see again.'

"I knew that the shore sloped toward the water and that I must be careful—that if I found the pearl high on the slope of the sand, it might roll away from me down into the water. I thought that if I could find my way to the water first and get on my hands and knees I could grope my way carefully up the slope as I hunted for the pearl.

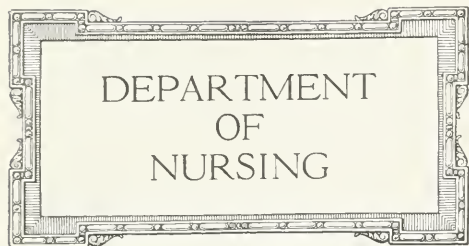
"I went down the slope to the water's edge, and getting on my knees I reached down and there was the pearl under my fingers. Praising the Lord I stood up, holding the pearl in my hand. My eyes were opened and I saw the sea, first the white of the surf and then the blue, the light of the sun on the water and the glory of the sunset—and there, my dear, my dream ended and I awakened with my hands hunting for the pearl in the bedclothes.

"And now," Aunt Patty said, "I want to tell you about my greatnephew. His mother and father are gone and my people are all gone, and he and I are the only ones of the generations that are left. He is a young officer in the engineers. A while ago, he was ordered to go to France, and he was given leave from one of the southern camps for long enough to come to say goodbye to me. We had a long talk. It was very hard to have him go, although I was very proud. I would not have any man of our blood stand back at this time. When he went away, he stood in the doorway and called back to me, 'Aunt Patty, when I come back, I want to see you sitting right in that rocking chair,' and I answered, 'My boy, I shall be here waiting for you.'"

And I believe that she will be.

American soldiers and sailors, and others whose powers of speech have been impaired, will be given every opportunity for recovery by the New York Clinic for Speech Defects. In connection with the clinic are maintained a medical department to care for the physical condition of applicants, a dental department, and a ward for the treatment of nervous and mental disorders affecting speech. It will also teach lip reading to those rendered permanently deaf and dumb by the war.

How many things, furniture, fixtures, shades, door knobs, window catches, and odds and ends, are out of order in your hospital—things that can be fixed by a mechanic or even by one of the floor men in a few moments? It is one of the loudest-speaking commentaries on the aliveness of the superintendent, that one thing of apple order in the institution.



Conducted by ANNIE W. GOODRICH, Principal, Army School of Nursing, and CAROLYN E. GRAY, Principal, City Hospital School of Nursing, Blackwells Island, New York.

Please address items of news and inquiries regarding Department of Nursing to CAROLYN E. GRAY, Principal, City Hospital School of Nursing, Blackwells Island, New York.

A Plan and the Equipment of a Model Teaching Unit for a School of Nursing

The rapidly advancing standardization of hospitals, necessitated by the demands of modern scientific medicine and surgery, has brought also a demand for better teaching equipment in schools of nursing. In nurses' residences erected in the past decade are increasingly found diet kitchens, laboratories, reference libraries, and classrooms with an equipment for instruction in nursing procedures that was little dreamed of in the early days of nursing education.

Many schools, however, are still struggling to obtain these most important factors in the education of the members of a profession in which scientific methods play so important a part. For their assistance, and as a suggestion for future nurses' residences, this plan for a teaching department and the equipment for the various rooms is presented.

The plan, selected as the best of a number submitted, was drawn by a former student in the department of nursing and health, Teachers' College, under the direction of Mr. Van der Bent, lecturer on institution planning. We are indebted to Miss Lindheimer, superintendent of the training school of the German Hospital, New York City, for the list of equipment—an equipment provided for the new nurses' residence of this institution and the most comprehensive we have yet seen. The list includes equipment for the demonstration room, trays of various kinds, diet kitchen, laboratory, and reference library.

DEMONSTRATION ROOM EQUIPMENT

FURNITURE	
2 tables.	Novocaine.
20 chairs.	Adrenaline.
1 bureau.	Ammonia.
2 enamel tables.	Turpentine.
1 gas stove (2 burners).	Mustard powder.
1 utility closet with glass doors.	Sweet-oil.
2 small closets.	Zinc oxide and olive oil.
1 private patient's bed.	Lassar's paste.
1 ward patient's bed.	Iodine.
1 crib.	Cantharidal collodion.
1 waste basket.	Sinapism.
1 linen basket.	Flaxseed.
1 screen.	Amylum.
1 towel rack.	Listerine.
1 clock.	Cantharides.
BEDDING	
6 feather pillows.	16 sheets.
1 hair pillow.	12 drawsheets.
1 crib pillow.	24 towels.
4 bath blankets.	6 bolster covers.
2 typhoid blankets.	24 pillow cases.
2 crib blankets.	3 shirts.
2 roof blankets.	4 bed-pans.
2 double blankets.	2 bed-pan covers.
2 nightgales.	6 hot-water bag covers.
DRUGS	
Silver nitrate 1 percent.	3 ice-bag covers.
Boric acid 2 percent.	

- 6 bedspreads.
- 2 cribspreads.
- 6 bath towels.
- 6 wash cloths.
- 3 dust cloths.
- 2 surgeon's aprons.
- 1 surgeon's gown.
- 1 surgeon's cap.
- 1 nurse's cap.
- 1 mouth binder.
- 1 pair sleeves.
- 1 pair lithotomy leggings.
- 1 pair surgical leggings.
- 1 pair knee caps.
- 1 laparotomy sheet.
- 1 perineal sheet.
- 2 pneumonia jackets.
- 4 arm slings.
- 1 shroud.

INSTRUMENTS

- 1 aneurism needle.
- 1 scalpel.
- 3 artery clamps.
- 1 bandage scissors.
- 1 needle holder.
- 1 tracheotomy tube.
- 1 Murphy button.
- 1 box assorted needles.
- 1 acupuncture needle.
- 1 mouth gag.
- 2 tongue forceps.
- 1 sponge holder.
- 1 douche nozzle.
- 1 glass catheter.
- 1 glass catheter, return flow.
- 1 anatomical forceps.
- 1 surgical forceps.
- 1 Cooper scissors.
- 1 straight scissors.
- 1 grooved director.
- 1 probe.

ENAMEL WARE

- 1 foot tub.
- 1 hand tub.
- 1 large basin.
- 6 medium basins.
- 6 small basins.
- 3 gray basins.
- 1 douche pan.
- 1 bed-pan and cover.
- 6 pitchers.
- 2 pails with covers.
- 2 funnels.
- 5 instrument trays.
- 2 pus basins, large.
- 2 pus basins, small.
- 5 white enamel spoons.

SPLINTS

- 2 Buck's—extensions.
- 1 solid—leg (Volkmann).
- 1 arm (Volkmann).
- 1 perforated (Volkmann).

ATOMIZERS, INHALERS,

- IRRIGATORS
- 3 DeVilbiss nasal.
- 3 DeVilbiss throat.
- 3 powder insufflators.
- 3 inhalers.
- 1 Maws inhaler.
- 1 crock kettle.
- 1 rubber bulb irrigator.
- 1 glass irrigator.
- 1 Fowler's ear irrigator.
- 1 nasal irrigator.

ICE-BAG SUPPORTERS

- 1 adult's ice-bag supporter.
- 1 child's ice-bag supporter.
- 1 ear ice-bag supporter.

RUBBER GOODS

- 1 mackintosh.
- 12 yards rubber sheeting.
- 3 bed sheets.
- 2 small rubber sheets.
- 2 pillow cases of rubber sheeting.
- 2 aprons.
- 1 pair rubber gloves.
- 1 Kelly pad.
- 1 ice-cap.
- 1 ear ice-bag.
- 1 ear and face ice-bag.
- 1 neck ice-bag.
- 2 rubber rings (large and small)
- 3 hot-water bags.
- 1 bath spray.
- 1 Leiter's coil.

ADHESIVE PLASTER

- Adhesive plaster zinc oxide on roll.
- Adhesive plaster zinc oxide sterile.
- Mole skin.
- Laparotomy straps.

Gauze rollers BANDAGES

- Flannel bandages.
- Muslin bandages.
- Plaster-of-Paris bandages.
- Starch bandages.
- Gauze bandages.

SETS

- Bladder irrigators.
- Rectal irrigators.
- Rectal irrigators, return flow.
- Turpentine stupe.
- Breast stupe.
- Rectal feeding.
- Lavage.
- Gavage.

MISCELLANEOUS

- Irrigating tips.
- Drinking tubes.
- Tongue-depressors.
- Safety pins (large and small).
- Plain pins.
- Sewing needles.
- Paper bags.
- 2 nailbrushes.
- 2 stopcocks.
- Matches.
- Toothpicks.
- Hypodermoclysis bottle.
- Hypodermoclysis needles.
- 1 Hagner hypodermic stand.
- 3 silk wax catheters.
- 1 sterilizing thermometer.
- 2 Eschmarch bandages.
- 3 tourniquets.
- 1 sphygmomanometer.
- 1 cardia dilator.
- 1 irrigating stand.
- 1 clotheshorse.
- 1 Bier's neck bandage.
- 1 straitjacket.
- 1 Hooper's restraining sheet and jacket.
- 1 canvas pack wringer with sticks.
- 1 oil-silk jacket.
- 1 premature jacket.
- 1 comb.
- 1 toothbrush.
- 1 back rest.
- 1 Chase doll.
- 1 doll, five-year size.
- Soap.
- Sapolo.
- Bon-ami.
- Green soap.
- 1 footstool.
- Bath sponges.

GAUZE AND COTTON

- Non-absorbent cotton.
- Absorbent cotton.
- Cotton balls.
- Gauze wipes (large and small).
- Gauze tampons (large and small).
- Cotton pads.
- Gauze packages, compresses.
- Fluffs, dressings.

TRAYS

- Catheterizing tray.
- Thermometer tray.
- Cupping tray.
- Enbrom tray.
- Medicine tray.
- Feeding tray.
- Mouth tray.
- Shaving tray.
- Eye tray.
- Scrub-up tray.
- Bath tray.
- Baby bath tray.
- Physical tray.
- Hypodermic tray.
- Breast tray.
- Simple dressing tray.

BINDERS

- 6 straight abdominal binders.
- 2 straight breast binders.
- 2 aspirating binders.
- 2 Scultetus binders.
- 1 T binder.
- 1 double T binder.

CLOTHING

- 2 shirts (male and female).
- 1 wrapper (female).
- 1 wrapper (male).
- 1 pair pajamas.
- 1 pair stockings.
- 1 pair socks.
- 1 pair slippers.

CHILDREN'S AND BABIES' CLOTHING

- 1 nightgown.
- 1 bathrobe.
- 1 pair pajamas.
- 1 flannel petticoat.
- 1 dress.
- 1 suit.
- 1 pair drawers.
- 1 pair stockings.
- 1 pair garters.
- 1 pair rompers.
- 1 pair slippers.
- 1 pair ribbon.
- 1 bib.
- 1 gauze diaper.

- 1 birdseye diaper.
- 2 Ferris waists.
- 1 nightshirt.
- 1 petticoat.
- 1 dress.
- 1 pair socks.
- 1 binder.
- 1 bonnet.
- 1 pair mittens.

MISCELLANEOUS

- 1 fracture board.
- 1 oxygen tank.
- 1 pair of boards for side of bed.
- 1 manikin.
- 3 charts (bone).
- 2 bed cradles.
- 2 shock blocks.
- 1 set of James' bottles.
- 1 drainage bottle.
- 1 irrigating can.
- 1 douche can.
- 1 Murphy can, with can protector and hot-water bottle cover
- 1 50-ounce solution bottle.
- 3 solution flasks.
- 5 glass jars.
- 1 pitcher for filling hot-water bottles.
- 1 instrument sterilizer.
- 1 electric stove.
- 1 pasteurizer (Freeman).
- 1 bottle rack.
- 8 nursing bottles.
- 2 nipples.
- 1 Chapin dipper.
- 1 tablespoon.
- 1 teaspoon.
- 1 graduated glass, 16 oz.
- 1 graduated glass, 250 c. c.
- 1 graduated glass, 75 c. c.
- 1 graduated glass, 1 dram.
- 2 tumblers.
- 1 bottle brush.
- 1 finger cots.
- 2 Vaseline.
- 2 chart covers.
- 2 card holders.
- 1 hernia band.
- 2 sand-bags.
- 2 stomach evacuators.
- 1 rectal dilator.
- 6 hard rubber tips for nasal and rectal irrigations.
- 1 Kemp's tube.
- 1 Tape.
- 1 Thread.
- 1 Unbleached muslin.
- 1 Flannel.
- 1 Rubber tissue.
- 1 Rubber tubing.
- 1 Connecting tubes.

CATHETERIZATION TRAY

- White enamel tray (12½ by 16).
- 1 solution basin with cover.
- 1 small tray.
- 2 rubber catheters.
- 2 kidney basins.
- 1 package towels.
- 1 package cotton wipes (sterile).

SIMPLE DRESSING TRAY

- White enamel tray (15 by 20).
- 1 instrument tray:
- 1 anatomical forceps.
- 1 surgical forceps.
- 1 Cooper scissors.
- 1 pointed scissors.
- 1 gauze scissors.
- 2 probes (large and small).
- 1 grooved director.
- 4 safety pins (large and small), sterile.
- 1 glass syringe.
- 1 medicine glass.
- 1 medicine spoon.
- 1 irrigating tip (with 8-inch rubber tubing).
- 2 spatulas (wooden).
- 1 solution basin (sterile).
- 1 kidney basin.
- 1 jar balsam Peru tampon.
- 1 jar boric acid unguent (sterile).
- 1 jar iodine packing.
- 1 jar silver nitrate sticks.
- 1 pair gloves.
- 1 package towels.
- 1 package dressings.
- 1 package cotton wipes (sterile).
- 1 package one-quarter inch adhesive.
- 1 package one-half inch adhesive.
- 4 laparotomy straps.
- 2 roll two-inch adhesive.
- 2 gauze bandages.
- 1 paper bag with safety pin.
- 1 dressing rubber.
- 1 bandage scissors.

DRY-CUPPING TRAY

- Metal tray (16 by 12).
- 8 Cupping glasses (various sizes).

- 1 alcohol lamp.
- 1 box matches.

DRY-CUPPING TRAY

- Metal tray (16 by 12).
- 1 bottle alcohol (95 percent).
- 1 tumbler.
- 1 metal and glass applicator.
- Cotton (absorbent) in small glass dish.
- 1 powder shaker.
- 1 tube vaseline.
- 1 large towel.
- 1 small towel.
- 1 compress.
- 2 kidney basins.

CONVULSION TRAY

- White enamel tray (12 by 9).
- 1 bottle chloroform.
- 1 anesthetizing bottle.
- 1 mask-holder with cover.
- 1 tube vaseline.
- 1 sponge forceps.
- 1 spoon.
- 1 tongue forceps.
- 1 mouth gag.
- 1 Few small wipes.

MOUTH TRAY

- White enamel tray (12 by 9).
- 1 mouth mug.
- 1 toothbrush.
- 1 glass tube with applicators, tooth-pick swabs, and tongue depressors.
- 1 bottle mouth wash.
- 1 jar cold cream.
- 1 jar bicarbonate solution.
- 1 jar aboline, boric acid, and lemon juice.
- 1 kidney basin.
- 1 towel.

MEDICINE TRAY

- White enamel tray (12 by 9).
- 1 Medicine glasses.
- 1 Medicine spoons.
- 1 Medicine droppers.
- 1 glass pitcher.
- 1 glass rod.
- 1 minim glass.
- 1 medicine list.

THERMOMETER TRAY

- White enamel tray (12 by 9).
- 1 glass jar covered with gauze compress (filled one-quarter full with bichloride 1-2500).
- 1 Rectal thermometers in tray.
- 1 glass jar with mouth thermometers, kept in alcohol 95 percent.
- 1 glass jar with tube vaseline.
- 1 bottle with alcohol 70 percent.
- 1 kidney basin.
- 1 Absorbent cotton in glass dish.

SHAVING TRAY

- White enamel tray (9 by 7).
- 1 razor.
- 1 glass jar with cotton sponges (with glass dish for cover).
- 1 bottle green soap.
- 1 jar with toothpick swabs.
- 1 towel.
- 1 roll toilet paper.

HYPODERMIC TRAY

- White enamel tray (9 by 7).
- White enamel dish (5 by 4) filled one-half full with carbolic acid 2 percent.
- 2 glass syringes.
- 2 glass spoons—kept in solution.
- 1 medicine dropper.
- 1 jar with cotton wipes.
- 1 glass tube with large hypodermic needles.
- 1 glass tube with small hypodermic needles.
- 1 glass dish for waste.
- 1 clamp.

FEEDING TRAY

- White enamel tray (12 by 9).
- 1 saucer.
- 1 feeding cup.
- 1 glass drinking tube.
- 1 teaspoon.
- 1 napkin.

SCRUB-UP TRAY

- White enamel tray (16 by 12).
- 1 bottle ether.
- 1 bottle alcohol 95 percent.
- 1 bottle iodine.
- 1 bottle flexible collodion.
- 1 alcohol lamp.
- 1 box matches.
- 1 medicine spoon.
- 1 tablespoon.
- 1 ethyl-chloride spray.
- 1 gauze bandage (3-inch).

- 1 Esmarch.
- 1 tourniquet.
- 1 kidney basin.
- 1 dressing-rubber.
- 1 small specimen jar with lysol.
- 1 small dressing forceps (kept in lysol solution).
- 1 test tube.
- 1 package towels.
- 1 package cotton wipes (sterile).
- 1 package dressings.
- 1 Few glass slides.

PHYSICAL TRAY

- White enamel tray (16 by 12).
- 1 pair examining gloves.
- 1 tube lubricatum.
- 1 towel.
- 1 auscultating cloth.
- 2 tongue-depressors (wooden).
- 1 tape measure.
- 1 kidney basin.
- 1 Few plain pins.

EYE TRAY

- White enamel tray (16 by 12).
- 1 small enamel basin for boric acid 2 percent.
- 1 candle with holder.
- 1 box matches.
- 1 kidney basin.
- 1 eye cup.
- 1 medicine glass.
- 1 roll 1-inch adhesive or silk court-plaster.
- 1 gauze bandage (2-inch).
- 1 towel.
- 1 dressing rubber.
- 1 bottle boric acid (saturated solution).
- 1 bottle argyrol 5 percent.
- 1 bottle pilocarpine 2 percent.
- 1 bottle cocaine hydrochloride 2 percent.
- 1 bottle homatropine 1 percent.
- 1 bottle atropine 1 percent.
- 1 jar white vaseline (sterile).
- 1 jar bichloride unguent 1-3000.
- 1 glass tube with eye applicator.
- 1 glass tube with dropper.
- 1 package eye dressing (sterile).
- 1 package eye pads.
- 1 package eye wipes.

BATH TRAY

- White enamel tray (16 by 12).
- 1 bath towel.
- 1 face towel.
- 1 wash cloth.
- 1 nailbrush.
- 1 soap dish with soap.
- 1 comb.
- 1 mouth mug.
- 1 toothbrush.
- 1 talcum powder shaker.
- 1 Toothpicks and orange stick.

Mouth wash.

- Alcohol 50 percent.
- Whisk.
- Cotton waste.

BREAST TRAY

- White enamel tray (9 by 12).
- 1 bottle boric acid 2 percent.
- 2 bottles alcohol 95 percent.
- 1 kidney basin.
- 1 jar toothpick swabs (sterile).
- 1 Package wipes.
- 4 adhesive straps with tapes.

BABY BATH TRAY

- White enamel tray (16 by 12).
- 1 rubber apron or piece oilcloth (with two safety pins).
- 1 baby bath blanket.
- 1 bath towel.
- 1 piece gauze for wash cloth.
- 1 baby shirt.
- 1 cord band.
- 1 diaper (birdseye) with safety-pin.
- 1 paper bag.
- 1 bath thermometer.
- 1 small enamel dish with sweet oil.
- 1 small enamel dish with boric acid solution.
- 1 talcum-powder shaker.
- 1 baby hairbrush.
- 1 scissors.
- 1 soap-dish with castile soap.
- 1 jar toothpick swabs.
- 1 jar cotton (sterile).
- 1 package with cord dressings.
- 1 dermatol shaker.
- 1 Thimble.
- 1 Thread and needle.
- 1 Alcohol 95 percent.

EINHORN FEEDING TRAY

- White enamel tray (16 by 12).
- 1 dinner plate.
- 1 bowl with hot water (bowl placed on dinner plate).

- 2 tumblers:
- One with feeding.
- One with saline solution.
- Apparatus (placed in tumbler with feeding).
- 1 glass syringe (placed in saline solution).
- 1 small glass with hot water.
- 2-inch piece thin rubber tubing.
- 1 towel.
- 1 Litmus paper.

DIET KITCHEN EQUIPMENT

- FURNITURE
- 1 blackboard.
- 1 china closet.
- 2 gas stoves with ovens and broiler.
- 12 gas stoves.
- 1 refrigerator.
- 3 porcelain sinks.
- 12 students' marble top tables with drawers, boards, and closet.
- 2 tables.
- 1 desk.
- 2 chairs.
- 12 stools.

UTENSILS—EQUIPMENT FOR TABLES

- 12 dishpans.
- 12 glass measuring cups.
- 24 white bowls.
- 12 lemon squeezers.
- 6 salt shakers.
- 12 pepper shakers.
- 12 asbestos mats.
- 12 spatulas.
- 12 knives.
- 12 forks.
- 12 tablespoons.
- 12 teaspoons.
- 12 paring knives.
- 12 apple corers.
- 12 soap dishes.
- 12 handbrushes.
- 12 asbestos holders.
- 12 custard cups.
- 12 muffin rings.
- 12 small strainers.
- 5 cake-cutters.
- 7 biscuit-cutters.
- 2 nutmeg-graters.
- 8 Dover egg-beaters.
- 10 wire whisks.
- 3 flour sifters.
- 12 double boilers.
- 12 sauce pots with covers.
- 12 sauce pots.
- 12 saute pans.
- 12 granite plates.
- 7 coffee pots.
- 6 granite bowls (two sizes).
- 6 granite plates (three sizes).

EXTRA EQUIPMENT

- Set of dishes for twelve persons.
- 12 glass dessert dishes.
- 12 sherbet cups.
- 12 drinking glasses.
- 6 egg cups.
- 2 pickle dishes.
- 1 gravy bowl.
- 2 platters (two sizes).
- 2 vegetable dishes (oval).
- 1 quart measure.
- 1 funnel.
- 3 vegetable pots (large).
- 2 vegetable pots (medium).
- 1 vegetable pot (small).
- 3 large cereal boilers.
- 1 stock pot.
- 4 sauce pots (various sizes).
- 16 tin-covers.
- 6 small granite frying pans.
- 1 pair butter paddles.
- 6 wooden spoons.
- 6 wooden spoons (split).
- 3 wire whisks.
- 2 small fine strainers.
- 4 meat forks.
- 1 bread knives.
- 4 case knives.
- 7 paring knives.
- 1 spatula.
- 3 ice picks.
- 2 carving knives.
- 5 basting spoons.
- 3 can openers.
- 2 vegetable scrapers.
- 1 corkscrew.
- 1 chopping bowl.
- 2 chopping knives.
- 1 Chinese strainer.
- 12 tin covers (large).
- 24 tin covers (medium).
- 3 tin covers (small).
- 1 large white double boiler.
- 2 pyramid toasters.
- 1 wire toaster.
- 1 marked basket (large).
- 1 marked basket (small).
- 13 Japanned trays.
- 1 granite coffee-pot.

- 1 granite teapot.
6 mixing boards (three sizes).
12 bread boards.
2 graters.
4 bread tins.
3 cake tins.
2 sets muffin tins.
1 iron skillet.
1 iron griddle.
1 steamer.
1 small teakettle.
2 small double boilers.
3 jelly molds.
1 potato ricer.
1 French frying pan.
2 Dover egg beaters.
2 skimmers.
1 cake-turner.
1 potato-masher.
1 soup ladle.
1 nutmeg-grater.
8 silver (nickel) knives.
11 silver (nickel) forks.
6 silver (nickel) tablespoons.
14 silver (nickel) teaspoons.
1 gravy ladle.
1 soup ladle.
1 glass sugar bowl.
1 glass spoon holder.
25 mustard cups.
1 bread box.
1 sugar can.
1 flour can.
1 salt can.
5 yellow bowls (odd sizes).
7 tin measuring cups.
24 jelly molds (tin).
1 fancy cook cutters.
3 muffin rings.
1 food chopper.
1 gram scales (with weights).
1 silver rack.
2 garbage cans.
1 window pail.
2 dust brushes.
1 small press.
12 large agate pans.
24 medium agate pans.
60 small agate pans.
5 four-quart pails.
12 two-quart pails.
6 dripping pans (three sizes).
2 colanders (two sizes).
1 dishpan (large).
1 dishpan (granite).
3 strainers.
1 vegetable dish (round).
2 creel slicers.
2 sugar bowls.
2 salt shakers.
2 pepper shakers.
2 cream butter pitchers.
3 aluminum trays (three sizes).
13 glass spice jars (three sizes).
1 lemonade shaker.
2 set of yellow bowls (six).
2 two-quart ice cream freezers.
1 ice bag and mallet.
2 rolling pins.
1 bag of cake tins.
2 square cake tins.
1 angel cake tin.
2 butter crocks.

LINEN

- 6 napkins.
24 dish towels.
12 roller towels.
1 set of three dollies.

MISCELLANEOUS

- 1 fancy teapot (bowls and cream pitcher).
2 earthen teapots.
2 small casseroles.
7 ramekins.
1 chafing dish.
1 glass fruit dish.

LABORATORY EQUIPMENT

CHEMICALS AND DRUGS, ETC.

- Ammonium sulphate.
Obernayer's reagent.
Benedict's volumetric solution.
Barro's qualitative solution.
Sodium hydrate N. 10.
Phenolphthalein.
Diethylamidoazobenzene (Top-sol solution).
I. K. solution.
Fehsch's solution.
Hypobromite solution A.
Baryte solution B.
Phenolsulphonphthalein ampules.
Aqua ammonia.
Hydrogen peroxide solution.
E. 22.
Oleum terebinthinae.
Alcohol 95 percent.
Solution nitro-prusside.
Solution nitric pure.
Acid acetic 2 percent.

- Acid hydrochloric pure.
Solution sodium hydroxide 10 percent.
Acid acetic glacial.
Solution ferric chloride.
Chloroform.
Tincture guaiac.
6 funnels, 12 by $\frac{1}{2}$ cm.
6 jars, 8 by 5.
3 alcohol lamps, 4-oz.
3 funnels, 7 by $\frac{1}{2}$ cm.
1 extra large funnel.
2 cylinders, 50 c. c.
2 cylinders, 100 c. c.
2 cylinders, 250 c. c.
4 cylinders, 500 c. c.
2 cylinders, 1000 c. c.
25 bottles, 4-oz.
3 wash bottles, 500 c. c.
6 flasks, 500 c. c.
12 beakers, 50 c. c.
12 beakers, 100 c. c.
12 beakers, 150 c. c.
12 beakers, 250 c. c.
12 beakers, 400 c. c.
12 beakers, 600 c. c.
6 evaporating dishes, size No. 0.
6 evaporating dishes, size No. 2.
6 evaporating dishes, size No. 4.
3 pipettes, 1 c. c.
3 pipettes, 5 c. c.
3 pipettes, 10 c. c.
3 pipettes, 25 c. c.
18 bottles, $\frac{1}{2}$ gallon.
6 graduates, 8-oz., 250 c. c.
6 graduates, 1-oz., 250 c. c.
1 Large laboratory table, soapstone top, for twelve students.
1 microprojector apparatus.
1 microscope, B. and L. D. S.
1 hot-air oven, 10 by 10 by 12, — 110 volts.
1 Arnold sterilizer (with thermometer).
1 Fren incubator, 12 by 12 (with thermometer).
1 urinometer complete set.
150 grams balance.
1 set metric weights, 1 cg. to 100 gm.
1 set apothecary weights.
6 tripods.
6 gauges (brass).
1 test tube clamp.
1 funnel support.
6 supports for twelve tubes.
3 ureometers.
12 urinometers 1000-1040, with cylinder.
4 aluminometers.
6 boxes slides (3 gross), medium 3 by 1, domestic.
6 boxes cover glasses (square $\frac{1}{2}$), 3 gross.
12 petri dishes, 100 c. c.
16 sediment glasses, 6 by $\frac{1}{2}$ inch.
1 gross test tubes, 6 by $\frac{3}{4}$ inch.
1 gross test tubes, 6 by 1 inch.
1 gross test tubes, 3 by $\frac{3}{4}$ inch.
6 jars, 6 by 6.
5 5-pint bottles.
Fehling's solution A.
Fehling's solution B.
Sodium carbonate anhydrous.
Lead acetate.
Pumice stone.
Solution caffeine sodium benzoate 25 percent.
Distilled water.
 $\frac{1}{4}$ solution eserine salicylate.
 $\frac{1}{4}$ solution eserine salicylate.
25 percent ether amphotarium.
20 percent oleum camphoratum.
Solution strychnine sulphate min.
10 containing gr. 1.15.
1 percent solution strychnine sulphate.
0.5 percent solution atropine.
1 percent solution atropine.
1:30 solution morphine Magendie's.

HYPODERMIC TABLETS

- Morphine sulphate, 1.8 gr.
Morphine sulphate, 1.4 gr.
Alcohol solution strychnine.
Strychnine, sulphate, 1.60 gr.
Nitroglycerine, 1:100 gr.
Digitalin, pure (Germ), 1:100 gr.
Strychnine sulphate, 1:50 gr.
6 glass rods, 24 by $\frac{3}{4}$ inch diam.
6 glass rods, 12 by $\frac{1}{4}$ inch diam.
1 glass rod (large).
1 record syringe, 2 c. c.
1 Luer syringe, 2 c. c.
1 metal syringe, 2 c. c.
1 sub-q-syringe, 2 c. c.
1 measuring glass, 250 c. c.
1 liter glass.
1 tablespoon.
5 outfits for sterilizing syringes and needles.
12 Bunsen burners, Fletchers with

- metal tubing.
6 packages filter paper, F. A., 12 $\frac{1}{2}$ cm.
6 packages filter paper, F. A., 23 cm.
Absorbent cotton.
Waste cotton.
Litmus paper (red and blue).
Matches.
1 soap dish and nailbrush.
1 white enamel pail.
1 stool.

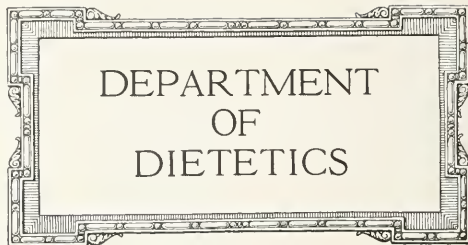
REFERENCE LIBRARY

- Surgical Nursing in War.....Bundy.
Physical Remedies.....Fox.
The Treatment of Emergencies.....Forn.
Technique of the Carrel Method.....Dumas and Carrel.
The Treatment of Infected Wounds.....Carrel and Dehelly.
Diet Computer.....Pope.
Standard Dictionary.....Gould.
Illustrated Dictionary of Medicine.....Gould.
Fatigue and Efficiency.....Goldmark.
Nursing the Insane.....Barrus.
Psychotherapy.....Muensterberg.
Massage—Its Principles and Technique.....Boehm and Painter.
The Psychic Treatment of Nervous Disorders.....Boehm.
Why Worry?.....Walton.
Health, Strength, and Happiness.....Saleeby.
The Influence of the Mind on the Body.....Dubois.
Physiology and Mental Diseases.....Forn.
Four Epochs of Woman's Life.....Galbraith.
Surgery and Society.....Saleeby.
Nervous Children.....Tucker.
Health Work in the School.....Forn and Terman.
Social Diagnosis.....Richmond.
Care of the Mouth and Teeth.....Kaufman.
Acute Polymyositis.....Draper.
Hospital Management.....Fones.
Mouth Hygiene.....Fones.
The Nation's Health.....Morris, Sir Malcolm.
Nursing Problems and Obligations.....Parsons.
Personal Hygiene and Physical Training for Women.....Galbraith.
Drugs and the Drug Habit.....Sainsbury, H.
Treatment of Infantile Paralysis.....Lovett.
The Sexual Life of the Child.....Moll.
Plain Facts, 4 vol.....Kellogg.
Question Manual.....Kennedy.
Twilight Sleep.....Hellman.
On Professional Education.....Albatt.
Nursing Ethics.....Robb.
Medical Electricity.....Abbott.
Human Mechanism.....Foster.
State Board Questions and Answers.....Hough and Sedgwick.
State Registration for Nurses.....Boyd.
Aquaminitas and Other Addresses.....Osler.
Invalid Occupation.....Tracy.
Medical Essays.....Holmes.
Self-Help for Nervous Women.....Mitchell.
The Spirit of Youth and the City Street.....Addams.
The Cost of Living.....Edwards.
The Cost of Cleanliness.....Richards, E. H.
The Education of Self.....Du Bois.
Accidents and Emergencies.....Dulles.
Surgical Nursing.....Dulles.
Memoranda on Poisons.....Tanner.
Bier's Hyperemic Treatment.....Meyer, Willy.
Preparatory and After Treatment in Operative Case.....Hanshold.
The Operating Room and the Patient.....Fowler.
The Operating Room.....Smith.
Elementary Physiology.....Huxley.
Materia Medica for Nurses.....Hartman.
Materia Medica for Nurses.....Deck.
Materia Medica for Nurses.....Paul.
Lectures on the Action of Medicines.....Brinton.
Textbook of Physiology.....Mullin.
Anatomy and Physiology.....Bundy.
Anatomy and Physiology.....Kimber.
Physiology of Alimentation.....Fischer.
Elements of Physiology.....Hough and Sedgwick.
Dust and Its Dangers.....Prudden.
Personal Hygiene.....Pyle.
Hygiene and Morality.....McIsaac.
Hygiene for Nurses.....McIsaac.
Hygiene of the Nursery.....Starr.
Hygiene and Sanitation.....Price, G. M.
Agricultural Bacteriology.....Jordan.
General Bacteriology.....Jordan.
Pathologie (German).....Niemyer.
Practical Hygiene.....Harrington and Richardson.
Microbiology.....Fisher and Williams.
Elementary Chemistry.....Bradbury.
The Chemistry of Cooking and Cleaning.....Richards and Elliott.
Chemistry for Nurses.....Ottenberg.
First Course in Chemistry.....McPherson and Henderson.
Household Chemistry.....Vulte.
Elements of Physics.....Henderson and Woodhull.
Bacteria Yeast and Molds.....Conn.
Bacteria and Protozoa.....Conn.
Physics and Chemistry for Nurses.....Bliss and Olive.
The Cost of Food.....Richards and Horton.
Chemistry of Food and Nutrition.....Sherman.
Essentials of Dietetics.....Pope and Carpenter.
How to Cook for the Sick.....Sachse.
Diet in Tuberculosis.....Bardswell and Chapman.
Practical Dietetics, Diet in Health and Disease.....Pattée.
Food and Cookery for the Sick and Convalescent.....Farmer.
Food Values, 2 vols.....Sack, E. A.
Dietetics for Nurses.....Friedenwald Ruhnah.
Food and Dietetics.....Hutchingson.
A Short Practice of Midwifery for Nurses.....Jellitt.
The Roller Bandage.....Hopkins.
Nursing in the Acute Infectious Fevers.....Paul.
Hospital Sketches.....Peabody, R. S.

Diet Lists of the Presbyterian Hospital, New York.....	Carter.
The Delinquent Child and the Home.....	Breckenridge and Abbott.
The Growth of Medicine from the Earliest Times to About 1800.....	Buck.
Handicrafts for the Handicapped.....	Hall and Buck.
Obstetrical Quiz.....	Carlson.
How to Know Your Child.....	Scott.
Mental Medicine and Nursing.....	Chase.
The Posture of School Children.....	Bancroft.
Abnormal Children.....	Hollander.
Dental Disease in Its Relation to General Medicine.....	Colyer.
Care of the Sick Room.....	Cutler.
The Relief of Pain by Mental Suggestion.....	Balten.
A Nurse's Handbook of Obstetrics.....	Cooke.
Surgical and Gynecological Nursing.....	Parker and Breckenridge.
Medical Gynecology.....	Kelly.
Reference Handbook of Gynecology for Nurses.....	McFarlane.
Diseases of the Eye, Ear, Nose, and Throat.....	Manhattan Eye, Ear, Nose, and Throat Hospital.
The School Nurse.....	Struthers.
Private Duty Nursing.....	DeWitt, K.
Primary Nursing Technique.....	Melsaac.
Obstetrics and Gynecological Nursing.....	Davis.
The Care and Feeding of Children.....	Holt.
The Care of the Baby.....	Griffith.
Diseases of Children for Nurses.....	McCombs.
Diseases of Infants and Children.....	Chapin, H. D.
Diseases of Infancy and Childhood.....	Holt.
Skin Diseases.....	McChan, G. N.
Quiz Book for Nurses.....	Pope.
Eye, Ear, Nose, and Throat Nursing.....	Davis and Douglas.
The Junior Nurse.....	Brown, C. A.
Fever Nursing.....	Wilcox, R. W.
Nursing: Its Principles and Practice.....	Robb.
Practical Nursing.....	Maxwell and Pope.
Modern Methods in Nursing.....	Sanders.
Under the Red Cross Flag.....	Boardman.
Life of Florence Nightingale.....	Cook, E. T.
Outlines of Nursing History.....	Goodnow.
Life of Clara Barton.....	Brown, P. H.
Life of Florence Nightingale.....	Tooley.
History of Nursing.....	Nutting and Dock.
Modern Treatment—The Management of Disease with Medicinal and Non-Medicinal Remedies.....	Hare, H. A.
A Mind That Found Itself.....	Beers, C. W.
The Unconscious Mind.....	Schofield, A. T.
Tuberculosis—A Preventable and Curable Disease.....	Knopf.
Social Work in Hospitals.....	Cannon.
Misery and Its Causes.....	Devine.
Public Health Nursing.....	Gardner.
Efficiency and Relief.....	Devine, E. T.
Democracy and Social Ethics.....	Adams.
Twenty Years at Hull House.....	Adams.
Home Economics.....	Parker, Maria.
Social Service and the Art of Healing.....	Cabot.
Human Mechanism.....	Hough and Pickwick.
The Other Side of War.....	Wormely, K. P.
Visiting Nursing in the United States.....	Waters.
Internal Medicine for Nurses.....	Farr.
Naturwissenschaften.....	Ule.
The House on Henry Street.....	Wald, L. D.
Principles of Sanitary Science and Public Health.....	Sedgwick.
Medical Inspection of Schools.....	Guilick and Ayres.
Orthopedic Surgery.....	Berry, J. McH.
Principles and Practice of Bandaging.....	Davis.
Essentials of Medicine.....	Emerson.
Sources and Modes of Infection.....	Chapin.
Nurse's Handbook of Medicine.....	Henry.
Diseases of the Skin.....	Jackson.
Manual of the Practice of Medicine.....	Stevens.
Gelenkrankheiten.....	Bonnet.
Art of Anesthesia.....	Flagg.

The Huntington Memorial Hospital, Boston, will erect a three-story laboratory building in the near future at an approximate cost of \$60,000. The basement of this new structure will contain a vault for storing radium and for experimental work in radio activity, and rooms for the installation of a highpowered X-ray apparatus. There will also be a carpenter shop, chemical and clinical laboratories, and a suite for the use of the resident physician. On the first floor will be rooms for out-patient cases, large biophysics laboratories, and rooms for X-ray and radium treatment. Practically all of the space on the second floor will be given up to laboratories of pathology and biology, while the top floor of the building will provide accommodations for the domestic help of the hospital.

One truth discovered is immortal, and entitles its author to be so; for, like a new substance in nature, it cannot be destroyed.—Hazzlitt.



Conducted by MISS LULU GRAVES.

Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, in care of THE MODERN HOSPITAL, Garland Building, Chicago.

DEHYDRATED VEGETABLES AND FRUITS

Economic Value of the Process of Dehydration—Advantages Over Canning

Dehydrated vegetables and fruits have come to stay. It is to be hoped that the unfounded prejudice against "dried fruit" has been permanently overcome. There is much to be said in favor of the improved process of dehydration, perhaps, but many of the dried fruits and vegetables which have been on the market in recent years have deserved more recognition as desirable foods than they have received. This method of preserving foods has been given much prominence by the U. S. Food Administration and others interested in food-saving. Bulletins are being issued by the department at Washington giving directions for drying vegetables on a small scale and describing the necessary equipment.

Community drying plants have been successfully operated in several places. In these central drying plants tops of vegetables and parings may be utilized as foods for stock, and it is conceded that some valuable by-products may be produced. One in particular has been mentioned—the making of cream of tartar from potato parings.

The economic value of dried vegetables is especially deserving of consideration at this time.

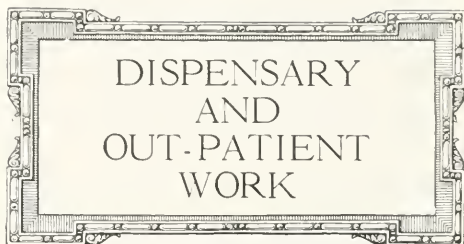
First, a perishable food material is changed to a form which is easily kept, thus eliminating waste due to decay or other forms of deterioration during marketing and transportation. It is to be hoped this will help very materially in a more adequate distribution, so that a shortage of any vegetable in one locality may be made good from another part of the country which has an abundance of this same product. This, too, should help to bring about a regulation of prices, and the man with the oversupply finds a market for his crop instead of allowing it to spoil in the field because there is no market for it at home and shipping it is apt to result in a loss.

Second, evaporation of the water from fruits and vegetables decreases the bulk and weight, thereby relieving the transportation difficulties very greatly. Their texture or quality is in no wise injured when compressed into tight blocks. Tin or wooden containers are unnecessary, as paper cartons will do, we are told by E. Clemens Horst, who has done considerable experimenting and investigating along this line. He further states that one carload of dried tomatoes equals in quantity thirty carloads of canned tomatoes. Again, it is said an entire barrel of spinach may be compressed into a package weighing but a few pounds. Aside from space and tonnage saved in transportation of dried vegetables, the saving of tin and

wood used in cans and boxes would mount to very large figures. Large orders for dehydrated vegetables, such as potatoes, onions, and carrots, are used by the British army to a much greater extent than by the American army. Major Murlin, of the food division of the Surgeon General's Office, in an address given recently in Philadelphia, spoke of the advantages offered by these foods in the army, so no doubt they will be used to as great an extent as they can be obtained. Major Murlin also called attention to the amount of time and labor saved in camp by the use of these vegetables.

These food materials may be made palatable in the same way that we have been accustomed to preparing dried fruits—by soaking for several hours and cooking in the same water in which they were soaked.

Some question has arisen with reference to the loss of mineral salts, particularly from the green vegetables, though it is still undecided as to whether or not this may be a serious matter.



Conducted by MICHAEL M. DAVIS, Jr.,
Director of the Boston Dispensary.

Please address items of news and inquiries regarding Dispensary and Out-Patient Work to the editor of this department, 25 Bennett street, Boston, Mass.

THE EVENING PAY CLINIC

A Successful Plan for Organized Medical Practice—Benefits to Patients and to Practitioners

By A. R. WARNER, M.D., Superintendent Lakeside Hospital, Cleveland.

The evening pay clinic is a dispensary, as we ordinarily understand the term, which is run in the evening instead of in the daytime and at which patients pay in the sense that they contribute fees large enough to provide compensation for all the physicians and other employees, as well as for all the expenses of the clinic.

The first evening pay clinic was started at the Boston Dispensary in 1913. The eye department was the first department in operation, but other departments were soon added. The second was started by the Brooklyn Hospital, Brooklyn, N. Y., in 1915 and the third in Chicago in 1916. The one at Lakeside (1917) was the fourth in this country.

The Lakeside Clinic opened in January, 1917, with two departments, the genito-urinary and the skin and syphilis. The attendance at these clinics rapidly increased, demonstrating the need in Cleveland for some such institution. That the clinic would run behind for a time was certain. Four of our trustees, Mr. Dalton, Mr. Bourne, Mr. Bingham, and Mr. Burke, agreed to meet the deficit of the first year. By the end of the year the clinic was on practically a paying basis but with an accumulated deficit of something over \$800. In January, 1918, a surgical department was added. Lakeside has a fairly large accident ward service, and many of the patients are workmen who desire to have the hospital complete the treatment of the accident ward. We have found that all the industrial firms were annoyed by the fact that accident cases which were placed in our wards, as soon as they became ambulatory, were discharged from the hospital and compelled to secure medical attention elsewhere. It seemed to them a more logical procedure for the hospital to complete ambulatory treatment in some department. There are also other patients, from both the hospital wards and accident ward, who desire the hospital to complete the treatment started, but the financial condition of many of these patients would not warrant their admission to our day dispensary. The growth of the clinic this spring has been extremely rapid. It is now again on a paying basis, and we are in the process of the establishment of an eye department. This department will be made up of a fully competent eye specialist, a high-grade optician to measure frames and check the glasses received with the orders, and nursing service to administer the drops.

The fees charged have been fifty cents for each visit,

Meeting of American Home Economics Association

The American Home Economics Association met in Chicago June 26-29. With the exception of Thursday's program, which was given at Hull House, the association met in Ida Noyes Hall, University of Chicago.

In common with all meetings being held now the greater part of the program dealt with subjects pertaining to war-time conditions. Particularly worthy of note was the talk given Friday morning by Mr. M. D. C. Crawford, editor of *Women's Wear*, on American textiles. He contributed a great deal of valuable information about clothing and materials, and especially about the dye situation. He laid emphasis upon the fact that colors which can be guaranteed are to be had, and may be had as easily and cheaply as at any previous time, but if we wish other colors than these we must pay the price necessary to make them.

Sessions were held by the science, institution, and extension sections which were both helpful and interesting. Round tables were held, and a visit was made to the kitchens of the Blackstone Hotel.

Miss Edna White, of Ohio State University, was elected president for the coming year, and Dr. Langworthy was elected vice-president.

Experiment in Drying Sweet Corn

Miss Logan, dietitian at the Anna State Hospital, had success last fall in curing sweet corn by drying it. Country Gentleman was the corn selected. It was blanched on the cob for five minutes, then cut from the cob, spread thin on pans and left in the baker's oven for thirty minutes at a temperature of 350. From the oven it was placed on muslin frames and left in a dry, warm attic for twenty-four hours. The corn has kept and retained its flavor. This summer the plan is to preserve a large amount in this manner. It is a much easier and surer method than canning.

Hospitals Make Their Own Hominy

The Anna and Jacksonville State Hospitals are making their own hominy from field corn. The recipe of the former institution is as follows:

Take ordinary field corn; dissolve one tablespoonful of lye in water; cover the corn with water and stir in the lye water; cook with steam to proper state then rinse the corn thoroughly with cold water. Much pains must be taken in the rinsing process.

with additional charges for medicine and supplies. These additional charges vary from twenty-five cents for simple prescriptions to five dollars for salvarsan injections. Competent practicing physicians were secured to take charge of the clinic, and are paid five dollars for two hours' work. The necessary clerk, orderly, nurses and some service by house physicians are compensated at proper fees. An allowance is paid the hospital for heat, light, stationery, and other routine articles.

One cannot properly appreciate what the evening pay clinic means to the community until one has talked to the patients. There is a certain proportion of illness of the workingman and his family which is acute and requires attention by a physician in the home. Into this field the evening clinic will never enter. There is, however, a large part of the medical treatment required, which is essentially ambulatory. This part is mostly in the specialties. It is most difficult for the workingman to secure this treatment, because it belongs in the specialties and the man's family physician cannot wisely serve him. It is also the most expensive treatment which he is called upon to provide for himself and his family. As a result, nearly all of the needed treatment is either never secured at all, or secured at some free dispensary. The greater part of the rest remains indefinitely on the books of some specialist whose routine schedule of prices is too much for the patient to pay. None of the three above-mentioned ways, namely, (1) going without treatment; (2) taking charity; (3) beating the specialist out of his bill, are very satisfactory to the average workingman. Therefore, when a man, needing treatment, realizes that this can be had from a competent specialist at a price which he has the means to pay and that his payments aggregated with others provides proper compensation to the physicians and other attendants, the satisfaction with the situation shown is often amusing, sometimes pathetic. The average workingman does not care to take charity, and is especially happy when able properly to provide for himself and family. Patients of the evening clinic express more gratitude and appreciation than those of the hospital and day dispensary combined, although their number is less than one-tenth as many.

It has been interesting to note the attitude of the physicians. The type of men selected were not those desirous of patients for practice or experience; they were young men grounded in their respective specialties, and actual cash receipts constituted the most acceptable basis for increasing their routine work. Five dollars for two hours' regular evening work was attractive to them, and they accepted the positions.

The equipment for the work is actually that required for a day dispensary, with this one distinction: in the evening clinic it is better to treat all patients as private patients, that is, to provide an inner or private office in which the physician receives all patients in privacy, in exactly the way that patients consult a private doctor in his office.

The pay clinic seems remarkably well adapted to the small hospital, especially in mill towns and sections of the cities surrounded by workingmen's homes. A hospital always has either a small dispensary, emergency treatment rooms, or other space which can be utilized in this way. A hospital always has equipment far exceeding that available in a private doctor's office. The organization and management of a clinic are simple. The point which usually looms as the big objection does not actually exist. This point is the objection to competition with the practicing physician. Work which requires the presence of the family

physician in the home at any stage of the disease is not undertaken. The work of the clinic is entirely special, work which the general practitioner cannot wisely attempt. Competition, if there be such, must be with specialists. There is no occasion to argue the obligation of the workingman to pay the average specialist's fees. It simply cannot be done by the most frugal and industrious of the working people. Specialists will do a certain amount of work for the laboring class at nominal prices, but it is to them a contribution of charity. A specialist's office hours are usually in the daytime and during working hours, making the loss of working time necessary, and often the man will call just the day when the office is filled with better paying patients. This is always unfortunate. The practice of the specialist among the laboring class is on the whole unsatisfactory, both to the specialist and to the people. There will not be an excess of those willing to give evening hours to their work. To some five dollars clear profit without expense of any kind, seems better than office hours, but the majority of specialists are not available for evening work.

Much is now said about organized practice of medicine versus the individualistic type. It is usually assumed that physicians as a whole are essentially of the individualistic type and opposed to organization. This is not true today, and there are doubts if it were ever true. The development of apparatus and equipment and the general type of work now required for the proper practice of medicine has placed undue burden on the medical profession. The cost of medical service to the medical profession has increased more than the ability of the people to pay for such services. It has become too expensive for each physician to maintain the equipment now actually required in the practice of medicine and to earn a fitting return for this expense and compensation for his preparation and training. It can be done if the fees are sufficiently high, but all kinds of work cannot be done on fees which the working man can pay. It is generally admitted that, on the average, half a doctor's income is required for the necessary expense of equipment, office, automobile, etc. If a physician should work for seven hours a day, at the rate paid in the evening pay clinic of \$5 for two hours, the entire payment in a year would amount to \$5,250, which would thereby be equivalent to a \$10,500 cash practice. How many physicians collect \$10,500 a year or better, and on seven hours a day work? No one in private individualistic practice ever did it on fees the laboring class can pay. Yet it can be done easily by organized practice. Some maintain that the organized practice of medicine would result in a surplus of physicians. This is not true, because nearly all of the work done by the evening pay clinics, which is a fair sample of the organized practice of medicine, is work which either is (1) not now done at all, or (2) does not now produce any revenue for the medical profession (free dispensary work), or (3) does not now produce enough revenue to pay the cost (present part-pay and mostly uncollected work of the specialists). The average net income of physicians in any form of organized practice would be markedly greater than it is today. The medical profession of England was at first somewhat skeptical about the panel system for their compensation in state insurance, but it is now established that these physicians are getting more money for their services than they have ever received before. There will be a few physicians hopelessly incompetent, whom no organization will accept under any conditions. The elimination of these few is a proper health measure which cannot be opposed by physicians themselves.

The exigencies of war may in the near future compel

the establishment in many communities of organized practice of medicine to provide medical care not only for the workingman, but for all the civilian population. The large numbers of the medical profession now in the army have created a situation wherein every physician is more than busy. Any way which will make it possible for the medical profession properly to treat larger numbers in less time should be given careful consideration and would be welcomed by the majority of the medical profession. The beginning of this may well be the establishment of evening pay clinics, especially in industrial centers.

* * * *

THE SOCIAL SERVICE EXCHANGE

Advantages to Clinics and Other Medical Institutions of Information Furnished Through This Agency

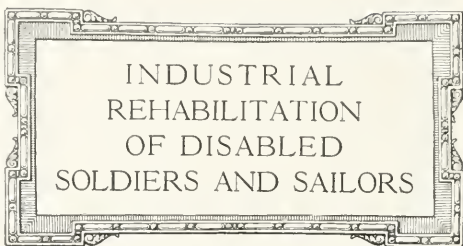
Social service agencies and medical institutions are gradually realizing their need of each other and coming to see how they can supplement each other's work. One of the most effective agencies for bringing about this correlation is the social service exchange. These exchanges exist now in many of the larger cities and their number is steadily increasing. They are organized for the purpose of providing their members with a ready means of ascertaining, through a central agency, what other members, if any, are interested in their client, and what they have done or are doing for them. This facilitates quick and intelligent handling of cases and avoids duplication of relief and other social service.

One of the largest and most active of these exchanges is the Social Service Exchange of New York City. In appealing to the dispensaries of New York, through the Associated Out-Patient Clinics, for greater cooperation in sending in the names and addresses of patients whose ailments are sufficiently serious to have some social or economic aspects, the New York Social Service Exchange points out the value of the clinic of information which can be secured from the exchange.

1. It will save time in making an investigation as to whether or not a patient is entitled to free treatment.
2. It will give a physician a quick survey of the general aspects of the home conditions of the patient.
3. It will enable the clinics and dispensaries to refer cases of need, either of material relief or some special social service, back to the agencies that have already worked with the same patients.
4. It will prevent patients from having contact with and being investigated by new agencies.
5. It will make available to other social agencies the information and experience of the clinics and dispensaries which is of great community importance.

It will be well for dispensaries to make inquiry as to the existence of a social service exchange in their respective communities, and, if one has been organized, to use it freely. It will save the dispensary needless waste of time in its social service work, protect the patient from unnecessary investigation, and increase the efficiency of the work of other agencies.

What have you in your attic? Most hospital attics are lumbered up with junk of every conceivable sort, the accumulation of years—and, as a rule, there isn't a stick in the whole mess that can ever possibly be used again. On the other hand, this mass of rubbish is an increased fire risk, it takes room that might be used to house screens during the winter and many other articles of actual value.



Conducted by ELIZABETH G. UPHAM,
Director Art Department Milwaukee-Downer College.

AN AMERICAN SCHOOL OF REEDUCATION FOR CRIPPLED MEN

The Work of the Red Cross Institute for Crippled and Disabled Men of New York City—The Methods of a Special Employment Bureau for the Handicapped

By DOUGLAS C. McMURTRIE, New York, Director of the Red Cross Institute for Crippled and Disabled Men, President of the Federation of Associations for Cripples, Editor of the American Journal of Care for Cripples.

[Continued from July issue.]

THE LIBRARY

As the institute is working in a new field, in which descriptive literature, reports, and studies are extremely scarce, it is absolutely essential to the intelligence of its work that it maintain its own library. The present library is made up of my private collection of literature concerning cripples gathered during the last eight years and by additions of the later material which have been acquired by the institute since its establishment. The collection contains every item relating to cripples which it has been possible to obtain either by purchase, gift, or exchange during the last eight years, and every care has been expended to make it as complete as possible. It can safely be said that the present library constitutes the largest collection in the world dealing with this subject, if not the only collection of considerable extent. The material covers work for crippled children as well as for crippled adults. It consists of approximately thirty-five hundred separate books, pamphlets, reports, and articles in periodicals.

The collection is completely indexed by author and subject, and there is now being made a minute analytical subject index which will refer not only to complete articles or reports, but to the separate sections and paragraphs of all the material. This will make possible, for instance, the immediate location of every reference in the literature to the teaching of motor mechanics or every reference to the provision of artificial limbs.

There has also been prepared a bibliography of the war cripple and supplements listing the current publications will be issued at frequent intervals. Over sixteen hundred items relating to the rehabilitation of disabled soldiers and sailors have already been indexed. The collection is used principally by members of the research staff of the institute, but it is open freely to the public for consultation and study.

RESEARCH DEPARTMENT

In entering upon a program of reeducation for crippled men, the first necessity was to learn the experience of others so as to avoid the mistakes which had been made and to follow out the methods which had been found suc-

cessful. This was not so simple as might appear, for the reason that there was no standardized practice, and, as the work was all so new, there had been little opportunity for reporting upon it.

The first effort was to ascertain all the centers on the continent, in Great Britain, and in Canada, at which re-educational work was in progress. Correspondence with the officials directing this work was immediately instituted, every available item of printed matter was collected, and photographs and illustrative material obtained.

The next move was to study the materials so gathered. This work was undertaken in the early summer by the present director of the institute and continued in the fall by a staff of research associates who were assigned to specialize individually on work in the various countries engaged in reconstructing their disabled soldiers. Thus, to one fell the responsibility of studying the work in Great Britain, to another of the work in France, to a third of the work in Italy and Germany, and to still another of the work in Canada and the other British dominions. As a result of these studies, there have been prepared reports describing the practice and organization of reeducation in the various countries. These are being issued as scientific publications of the institute.

Among the reports already prepared and issued are publications describing work in Canada, Great Britain, France, New Zealand, Germany, and Italy.

PUBLIC EDUCATION

In the rehabilitation of disabled men, an absolute essential is cooperation on the part of the public. The community must have intelligence regarding the methods and sympathy with the aims.

Up to the present time, the attitude of the public toward the cripple has been singularly pernicious, and of decided hindrance rather than help in his efforts to make good. The people have been ready—all too ready—with sympathy proceeding from the heart but not from the head. There have been alms in plenty for the cripple on the street and public asylums open to shelter him. But there has been no assistance of a constructive nature. The hospitals in which he was treated turned him out before he was in shape to face life again; there have been no schools in which he could be trained for a trade possible to his capacities. Even for those in a position to do work of a certain character, there have been no special placement agencies to seek out for him the suitable job.

Employers have considered the cripple helpless and have denied him opportunity of trial at any job worth while. A position as watchman or doorkeeper was about the best he could expect.

The individuals among the family or acquaintance of the cripple have condoled with him regarding the black future ahead. They have assumed him helpless and, only too often, convinced him of the validity of their surmise.

It is evident that, if reconstruction work with crippled men is to be successful, this attitude must radically be altered. The employer must be brought to think: "Too bad, but we must not think of any charity job. We must look around to pick out for you a job at which you can be as useful as before the amputation." The reaction of the individual must come to be: "That was hard luck, but you will get along all right. Think of all the cripples, more seriously disabled, who have made real successes and are now happy and self-supporting."

The public demand on the cripple must be that he fight for his independence, rather than subside into an object of pity. And the community must then be prepared to stand by with the right kind of help.

One duty of a pioneer institution thus becomes clear. The pernicious attitude can be metamorphosed only by an extensive, persistent, and patient campaign of public education. The institute has accepted its share of responsibility in this field and has inaugurated educational effort directed through a variety of channels.

The work of reeducating disabled soldiers for self-support is one which has laid hold of the public imagination in the European countries. There seems no better method of committing our own countrymen to similar effort than to tell in the public press, in an interesting fashion, of what is being done abroad. A news service to the daily press, sent out about once a week, has been instituted, and it has been found that the material has very generally been utilized. The first story told of the reconstruction of crippled peasants in Italy; the second described the splendid accomplishment by the Belgian authorities in making their disabled and expatriated soldiers a national asset rather than a liability. The third article recounted the work of a great reeducational school at Dusseldorf, Germany, and pointed out several ways in which we might learn from our enemy; the fourth story dealt with the pioneer effort in France to build up facilities for rehabilitation of the crippled *poilu*, and there are many others which have been sent out, or which are in preparation. It will be noted that these are not publicity stories, but real news articles. The institute is not mentioned in them, except to assume responsibility for the statements made.

A related activity has consisted in writing "letters to the editor" purposed for publication in the daily press throughout the country. The general aim of these letters is to call attention to matters of moment to the cripple. One asked for suggestions from readers as to jobs in which one-armed cripples could profitably be employed. Many helpful replies were received, but the chief advantage was derived in the large number of people who were brought to think about the question.

When occasion demands, there are issued to the daily press bulletins of different character, with the purpose of informing the public regarding the actual activities of the institute—its establishment, the inauguration of new departments, and current work. By "letters to the editor," the attempt is made to reach employers and interest them in the objects; also to reach cripples and inform them of the facilities at their disposal.

Periodical articles, with their excellent possibilities of illustration and the special character of their circulation, offer an apt medium for educational material. In an effort to reach directly the workers and employers in as many industries as possible, there have been prepared, for the trade journals, a series of articles. Each article is specially written for the trade in question and tells of instruction in that trade actually being given to war cripples in the reeducational schools abroad, thus reaching the reader on the field of his own particular interest as related to the war. Contributions on the reeducation of war cripples in the electrical field, in leather work, in shoe-repairing, in jewelry-making, and in carpentry have already been published.

The institute has gathered an extensive collection of photographs illustrating reeducational work in all the belligerent countries. This now numbers over three hundred subjects.

From the most interesting subjects in the photographic collection have been made sets of lantern slides. The institute is also building up a collection of moving picture films illustrating the work of reeducational centers in

other countries, or showing successful cripples in action. The latter reels prove a great encouragement to disabled men.

With interest in reconstruction work growing apace, the demand for speakers to discuss the subject before conventions and meetings of one type or another has been frequent. Members of the institute staff have endeavored to respond to every reasonable request.

In order to take the initiative in preparing for discussion of reeducation for crippled and disabled men before a larger number of audiences, there has been organized a speakers' bureau for which volunteers were recruited and trained.

This article is not a record of accomplishment, for the institute is only entering upon its task—a difficult task, indeed. Its principal purpose is to interpret the problem of the military and industrial cripple as it has been seen, to indicate how some of the preliminary questions have been decided, and to describe the methods and manner of attack on the citadel of the reeducationist's intention.

There is no royal road to wisdom in dealing with the cripple. Experience is the only dependable teacher. What little of such experience the institute may have at any stage of its development will always be available to others who may come to share its enthusiasm and aim.

Smith-Sears Bill Passed

The United States has taken the first step in providing rehabilitation for her disabled soldiers and sailors by passing the Smith-Sears bill, which became a law June 27.

The outstanding features of the bill to provide that all occupation given for therapeutic purposes is under the direction of the Surgeon-General in consultation with the Federal Board for Vocational Education, so that such occupation may be, wherever possible, a part of a continuous course of training, and that the Federal Board for Vocational Education shall provide all vocational training after the men have completed their hospital treatment and are discharged from the army.

Since Congress has appointed the Federal Board for Vocational Education responsible for all reeducation after the soldier's discharge from the hospital, this Board is engaged in building up an organization for the discharge of this mammoth task. In this effort the Canadian government is proving of great assistance in lending Mr. T. B. Kidner, vocational secretary of the Invalided Soldiers Commission to the Federal Board as advisor. Mr. Kidner has been called to Washington in consultations during the past winter, and testified at the hearings of the Smith-Sears bill. The knowledge that Mr. Kidner is to assist the American government in this great enterprise is welcomed throughout the country by those interested in rehabilitation who know of Mr. Kidner, his vision and work in helping to develop the present organization in Canada.

The experience of all the countries in rehabilitation has been compiled by Douglas C. McMurtrie, director of the Red Cross Institute for Crippled and Disabled persons, and published by the Federal Board for Vocational Education as Bulletin No. 15 entitled: "The Evolution of National Systems of Vocational Reeducation for Disabled Soldiers and Sailors." This bulletin will be sent free upon request.

Look inwards, for you have a lasting fountain of happiness that will always bubble up if you will but dig for it.—Meditations of Marcus Aurelius.

THE SOUTH'S FIRST SCHOOL OF SOCIAL WORK AND PUBLIC HEALTH NURSING

Courses in Public Health Nursing—Field Work in the Public Health Service of Richmond—Training Social Workers for War-Time Work

By HENRY H. HIBBS, JR., Ph.D., Director, School of Social Work and Public Health, Richmond, Va.

Last fall there opened in Richmond, Va., the first school for social workers and public health nurses to be established in the South. It was established partly as a result of a long-felt need for more available opportunities for training in the South and partly to meet the increasing need for social workers and public health nurses which the war has produced.

The lack of any well-organized school for the training of public health nurses and social workers in the South has been the subject of comment for some years. As the chief health officer of a large Southern city has pointed out, "We are forced to employ graduate nurses with no social or public health training with the hope that after we put them to work we can give them the social and preventive viewpoint which the health nurse must have to be successful. But too often this is a vain hope. However intelligent and devoted to her work the nurse may be, we find that the pressing requirements of her daily routine prevent her from acquiring, or the chief nurse from teaching her, the things the ordinary graduate nurse must learn to become successful in public health or visiting nursing."

Organizations and individuals interested in public health nursing have hoped that such a school might be established in Richmond because of the extraordinary fine visiting nurse service for which Richmond has been justly famous for many years, and because both the city and state departments of health have recognized the importance of public health nursing and provided liberally for it. With so admirable a background for field work, writes Ella Phillips Crandall, secretary of the National Organization for Public Health Nursing, "we have looked upon Richmond as the most strategic city in the South for such a school."

Such a school has now been established in Richmond as a division of the School of Social Work and Public Health. The school opened on October 1 with two students enrolled in the eight months' course and four in the four months' course. This enrollment, while very small, was not regarded as discouraging, since plans had been made rather hastily and no well-organized effort had been made to get the advantages which the school offered and the need for public health nurses before the graduate nurses of the state.

A four months' course was later announced to begin February 1. This course was more carefully planned, and every effort was made to interest the nurses of Virginia and neighboring states. As a result, a gratifyingly large body of students was enrolled in a relatively brief period of time. Eleven of the nurses came from Virginia, five from North Carolina, and one each from South Carolina, Tennessee, New Jersey, and Kentucky—a total of twenty.

The courses offered are as follows: (1) public health nursing; (2) public health nursing (advanced); (3) sanitation and preventive medicine; (4) the health of school children; (5) public health administration; (6) publicity in public health work; (7) mental hygiene and mental disease; (8) general introduction to social work; (9) community social work; (10) economics.

THE WAR: ITS HOSPITAL, MEDICAL AND NURSING ASPECTS

Work of English Sculptors in Repairing Facial Injuries

Captain Derwent Wood, A. R. A., does work of a most unusual character; he is a builder of human faces. Working in the Masks for Facial Disfigurements Department,



Copyright Underwood & Underwood, New York.

Fig. 1. Various plates and attachments in different stages of completion. The lower row, from left to right, shows the mask mold, the mask cast, the cast with the good eye restored, the plate molded, and the finished plate attachment.

Captain Wood transforms the hideous, often faceless, wrecks of war into men whose countenance shows no repulsive features. New noses, eyes, cheek-bones, jaws,



Copyright Underwood & Underwood, New York.

Fig. 2. British official photograph showing the patient examining the mold of his own face.

sometimes almost entire new faces are constructed by Captain Wood, who before the war was a sculptor.

Ward Muir, in the *Nineteenth Century Magazine*, de-

scribes the work done by Captain Wood and other sculptors. The injured soldier, if possible, provides a portrait of himself before his injury. This serves as a model for the sculptor. Next a cast is made of the patient's face and the cast is put through various processes to make it a perfect basis for the artist, who then builds up the new face.

"The eyeless socket is filled in and given an eye, eyebrow, and eyelashes which pair with their neighbors; the concave cheek is made convex to pair with the good cheek; the nose is restored, its shape reproduced from measurements and from comparison with the photograph."



Copyright Underwood & Underwood, New York.

Fig. 3. A patient with a plate which has been fixed to hold spectacles to cover the wound. The sculptor was Captain Derwent Wood, R.A., Third London General Hospital.

A mask is made from electrotype plate, paper-thin. At first it is not tinted but is shaped with great care. "Very painstakingly is the patient fitted." The plate is then covered with an electric deposit of silver. The artist then paints, on a slim oval disk of glass, an eye which is a marvelous reproduction, even to the veins in the white, of the patient's uninjured eye. The mask is completed by being painted in colors which are an exact match for the patient's skin. Little support is needed for the mask, as it is very light.

"At a slight distance, so harmonious are both the molding and the tinting, it is impossible to detect the join where the live skin of cheek or nose leaves off and the imitation complexion of the mask begins. Figure what this means to the patient."

* * * *

CORNERSTONE OF FIRST RECONSTRUCTION HOSPITAL LAID

Order of Elks Present to the Government Reconstruction Hospital on Parker Hill, Boston

On June 15 the cornerstone of the first hospital in the United States thus far dedicated to the reconstruction of maimed and disfigured American soldiers was laid on Parker Hill, Boston, adjoining the Robert Brigham Hospital and overlooking Bunker Hill and the historic heights of Dorchester. It will be known officially as Government Hospital No. 10. This reconstruction hospital will cost about \$250,000, and is one of a series to be erected later

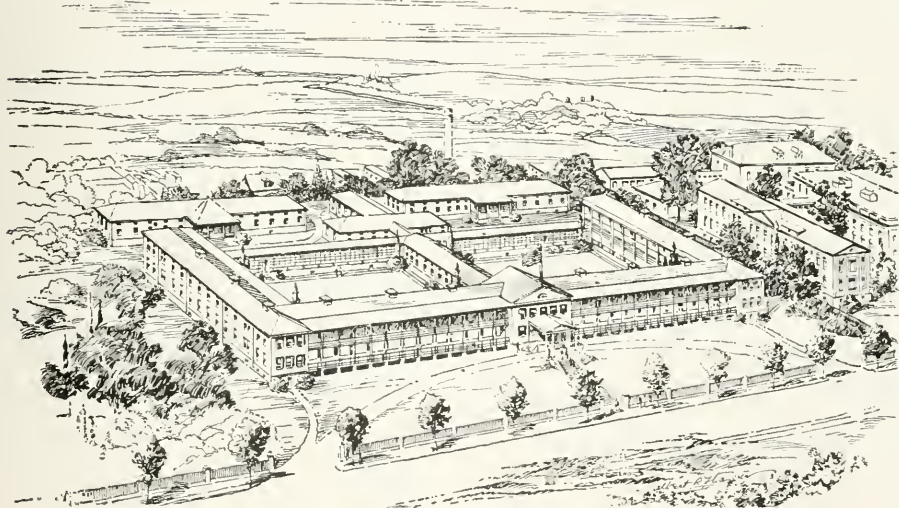
by the grand lodge of the Benevolent and Protective Order of Elks from a fund of \$1,000,000 which was raised by the various lodges throughout the country.

When the Order of Elks met in annual convention last year in Boston and faced the question of what they as an order might do to assist the government in the prosecution of the war, the seventeen hundred members there gathered unanimously voted \$1,000,000 for war relief. A commission appointed to determine the use to which the money was to be put decided that the principal purpose for which the money should be spent should be hospitals, and learning that it was the desire of the government to establish its first orthopedic or reconstruction hospital in Boston, made haste to offer to purchase a site and erect suitable buildings for the purpose, an offer which was gladly accepted by the United States soon after its general nature and plan were unfolded. The site next to the Robert Brigham Hospital was chosen because the trustees had come forward with the offer of every pos-

divided into seven small wards for the use of the commissioned officers who will be assigned by the war department to the management of the hospital.

The central part of the main building contains a large hall, two administration offices, one on each side of the entrance, and a double staircase to the second floor. Running back from this central portion of the main building through the center of the square formed by the ward buildings and the corridor which connects them at the rear is a large mess hall and serving room. The hospital will be supplied through the tunnel and corridor from the kitchen of the Robert Brigham Hospital.

A large elevator will run from the basement to the second floor. In the rear of the connecting corridor is to be built the hydrotherapeutic department. This is to be constructed in the shape of a cross and divided into three compartments, each one devoted to a different method of treatment, one for baths, one for massage and one for exercise rooms.



Reconstruction hospital now being built on Parker Hill, Boston, by the Benevolent and Protective Order of Elks.

sible help from its fine central plant in the way of light, heat, kitchen, laundry, chemical laboratory, x-ray facilities, and operating room. This had made it possible to avoid heavy construction and thus hasten the work. It is expected that the buildings will be ready for occupancy on October 1 next.

Every device and resource known to science will be on hand to rebuild every part of the human frame. Dr. Frederick J. Cotton, it is reported, will be in charge of the hospital for the government. The hospital will require a well-trained and especially efficient professional staff. Its necessary nucleus has been recruited and will be ready to begin its work as soon as the hospital buildings are completed and equipped.

From the plans of this hospital and from the experience gained there it is intended to establish the model for reconstruction hospitals throughout the country. The main building will consist of seven open wards, two stories high, each containing a diet kitchen, toilet arrangements, day room, nurses' room, and linen closet. These wards provide for thirty-four beds each. An eighth ward is

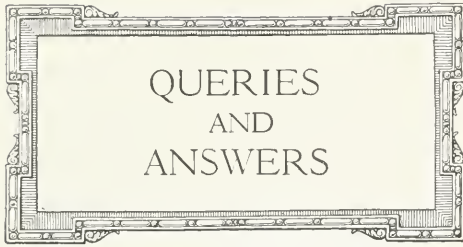
In the rear of the ward buildings and contiguous to the hydrotherapeutic department, on each side, are to be the shop and barracks. The shop building will be divided into two departments, where the patients of the hospital will be taught to use their restored members and be instructed in new trades.

In the barracks will be housed the orderlies and male employees connected with the hospital. The general style of the building suggests the southern colonial.

The Board of Trustees of the German Hospital, in Brooklyn, has dropped the old name, and are now calling the institution the "Wycoff Heights Hospital."

"Doctor, if I follow all the rules you have given me life won't be worth living."

"That is for you to judge, sir. Under those conditions I don't believe life would be worth living, either, but as a conscientious physician I must tell you what you'll have to do to regain your health."—Birmingham Age-Herald.



Affiliation for the Small Hospital

To the Editor of THE MODERN HOSPITAL:

I should like to ask your advice about a question concerning the policy of this hospital which is very important to us at present, in fact, a question that has aroused so much controversy that the solution of it will probably decide whether the work of the hospital will be continued or not.

We are in a very small city, but the people of the town and the surrounding towns are dependent on us for hospital care. We have only 25 beds, and our average daily census is not more than 13.

When the hospital was first opened, we had a training school, but found it expensive to train nurses and hard to get probationers for such a small school, as our graduates could not register without further training in a larger hospital.

The training school was discontinued about two years ago, and we have been taking in girls who receive a small salary, and we give them what practical training we can in the care of patients. This plan is objected to by the registered nurses of the state, and they are creating a lot of gossip about the care of our patients. On account of this, it is getting to be difficult to get graduate nurses to care for special cases in the hospital or to take charge of the nurses. We should appreciate any advice you can give us.

A SUPERINTENDENT OF A SMALL HOSPITAL.

Twenty-five-bed hospitals can and do support training schools and give nurses good training so far as their clinical material will supply it, and make that training fully meet the requirements for state registration by an affiliation with one of the large hospitals of the state. Unless you can do this, the next best thing for you to do would be to engage enough accredited graduates to care for your patients.

How to Lay Battleship Linoleum

To the Editor of THE MODERN HOSPITAL:

Will you kindly tell me the best way to lay battleship or any other good linoleum on worn wooden floors?

A CANADIAN HOSPITAL.

Wooden floors should be perfectly dry before linoleum is laid. The surface should be smooth and even and free from all dirt and foreign matter. A good carpenter can scrape the floors so as to produce a satisfactory surface. All cracks must be filled and protruding knots or nails must be smoothed down. The preliminary preparation is very important because any unevenness in the floor will in time show in the linoleum. Moisture on the floor will cause mildew or mold. The linoleum may be laid either directly over the wooden floor or over a layer of felt paper.

Linoleum floors are most satisfactory laid over a cement base. The success of the flooring seems to depend on the material used to hold it to the base which will not cause raised places after the wear has begun.

Floors of linoleum tiles or squares are more easily repaired and kept in condition, and cracks or raised places are easily avoided by the repair of one or more tiles at a time, when necessary.

The Graduate Night Supervisor a Necessity

To the Editor of THE MODERN HOSPITAL:

Do you consider it necessary in a small hospital of only thirty-five beds to always have a graduate nurse in charge of the hospital at night? Besides myself, there is one day assistant, who also serves in the operating room. Our trustees do not want to add a third graduate to the salary list, and wish me to keep a senior nurse in charge at night and my assistant on call when needed. Will you let me know what other hospitals are doing about this?

SUPERINTENDENT OF SMALL HOSPITAL.

This question arises frequently in the smaller hospitals. The salary list is a rather serious part of the economic problem and must be considered, but, on the other hand, we believe that doing without the graduate night supervisor is poor economics.

No graduate assistant can give good supervision to the hospital in the daytime and be subject to call at night, and no senior nurse should be asked to take the entire responsibility for obstetrical cases, emergencies, or the post-operative care of patients.

You will find that just one accident in your hospital or one case, of either real or fancied neglect, which can be laid to the lack of a night supervisor, will do your hospital more harm in the community and prove a greater economic loss to you than can be balanced by the money saved on the salary list.

Redecoration of Operating Room

To the Editor of THE MODERN HOSPITAL:

We are writing you concerning the redecoration of our operating room in our local hospital. This room is about 14 by 18 with a large bay window facing the east.

The plastering consists of two-coat work. The white coat commenced cracking and chipping off about four years ago. We then repaired the breaks and decorated the walls with wall paint, but have the same trouble again only worse. We would like to avoid removing the plastering if possible. Are there any paper or oil cloth compositions that could be used? If this is possible, would a soft gray be more suitable than white?

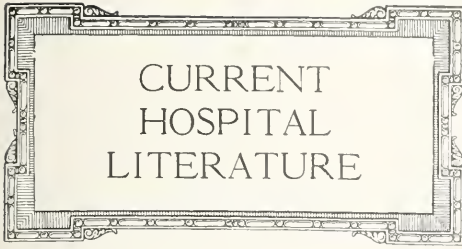
A MIDDLE-WESTERN HOSPITAL.

Old plaster walls in an operating room such as you describe could be covered with a glossy finished oilcloth, applied in a manner similar to the application of wall paper, but it is doubtful whether the cracks and pits could be filled smoothly enough to produce a good result.

Assuming that your plaster is on clay tile, gypsum block or metal lath, the appearance and wearing quality would be more satisfactory if you would have the white coat of plastering removed and a thin coat of Keene cement applied. An experienced plasterer acquainted with the working of this cement would insure a permanent perfectly smooth job for oil painting or enameling which should not have any imperfections, such as would be visible through any oilcloth material applied on existing plaster work, however careful the attempt had been to smooth over the defects.

A soft gray or light green color is now generally considered more suitable than white for the walls of operating rooms. It is now recognized that the effect of the reflection of bright daylight from the floors and walls on the eye of the operator causes an eye strain that affects in an unsatisfactory manner quick and accurate work, and there is coming to be a preference for gray or green-walled operating rooms.

The world would be better and brighter if our teachers would dwell on the duty of happiness as well as on the happiness of duty.—Lubbock.



ALBERT ALLEMANN, M. D., Foreign Literature.
*Army Medical Museum and Library, Office of the Surgeon-General,
 United States Army.*

The Work of the Adolescent Clinic of Stanford University Medical School. Amelia E. Gates, M.D. Arch. Pediat., 1918, XXXV, No. 4.

About a year and a half ago, a separate clinic for girls from 11 to 16 years old was established at the out-patient department of the Stanford University Medical School as a branch of the children's clinic. The work aims to embrace the prepubescent, pubescent, and early postpubescent period, and Dr. Gates' report is based on the work done with the first hundred girls. While certain medical aims were in view when the work was started it was soon found that it was not possible to confine it to medical work alone. In proportion as the social and educational aspect of the problems was dealt with, the work became more effective. The interest taken by the mothers in the work and their intelligent cooperation is said to be most gratifying. The clinic is held once a week after school hours so as to allow of frequent presence without loss of school attendance. During the year and a half of its existence the clinic has assumed the character of a girls' club. Manual work such as bead-making, basket-weaving, etc., has been introduced, and many of the girls look forward to the Wednesday afternoons and their little talks with the clinic staffs, knowing that they can bring their small troubles and worries there with assurance of sympathetic understanding and attempt at effective help, for physical ailments are not the only ills dealt with in this clinic, but also those coming from the various social maladjustments of modern life, such as uncongenial or inappropriate home environment, mental overstrain, and worry over vocational choice.

The medical problems of adolescence fall into three divisions, those dealing with physical, mental, and psychical state of the individual. Among the conditions specially studied are physical development (as indicated by increase in weight and height); the anemias; the menstrual disturbances; the condition of the thyroid; the vasomotor disturbances; the nervous disorders; postural defects; the different forms of enuresis. Failure to make gain in weight and height in proportion to age is found to be due in many cases to insufficient nourishment, and whenever a girl in good physical health is not making a satisfactory gain in weight, the quality and quantity of her food are thoroughly investigated. Direct medication for anemias has been largely abandoned in favor of general hygienic measures, good food, fresh air, cold bathing, etc. In the treatment of anomalies of menstruation the work has been largely educational and the results have been very satisfactory.

In the investigation of the mental status of the patients, the Binet-Simon scale showed a retarded mentality of from one to five years in 71 percent of cases, and the conclusion

was reached that the adolescent period was one of mental arrest. A check on these results by means of a point scale forced a revision of this conclusion, indicating that many who had tested out much retarded by the Binet scale were normal by the point scale. Dr. Gates concludes that while the Binet may be adequate in the examination of children below eleven, after that age the point scale is far more reliable.

In dealing with the psychic phenomena, work with the parents is as important as that with the patients themselves. An interesting observation is that the psychic problems are easier to solve in the case of girls from the associated charities under the care of a foster mother than in those who are in their natural families, for in the former case, if the mother be not the right sort or the environmental influences not the best for the child, the mother can be changed and the right surroundings secured, but uncongenial home surroundings cannot be discarded in the case of a child under the care of her own family. The abnormal psychic conditions most frequently found are lack of emotional control, increased sensibility, over-anxiety as to physical condition, and overconscientiousness leading to depression. No recognized case of dementia precox was found.

On the social service side of the work much is to be done, and a small corps of social workers could be kept busy. Two of the most pressing needs are instruction in dietetics to the mothers and provision of wholesome amusement for girls in their leisure hours.

Physical Status of Juvenile Delinquents Based Upon Physical and Clinical Examinations of Children in the Reformatories of the City of New Orleans. Elizabeth Bass, M.D., and Maud Loeber, M.D., South. Med. Jour., 1918, XI, No. 5.

Drs. Bass and Loeber undertook this study to ascertain the condition of the children committed by court order to the reformatories in the city of New Orleans with the purpose of discovering physical conditions which might have a direct bearing upon crime. The question raised by the authors is whether the court should not be in possession of such facts before the disposition of the case is made. Only tests within the scope of a routine office examination were made, since it was considered that possibly only a short time would be permitted a physician appointed by the court for examining children prior to their final commitment. The examination made covered general appearance, posture, development, and nourishment, including under "head," scalp, eyes, nose, mouth, teeth, throat, ears and glandular enlargements; under "chest," the heart and lungs; under "abdomen," normal or abnormal, distended, presence of masses; under "special," skin and reflexes; under "clinical," blood, differential leukocyte count, and under "feces," presence of intestinal ova or parasites. Wassermann, sputum, and urine examinations were made only on children whose general appearance or physical findings suggested a condition where these examinations would aid in diagnosis. The author says:

"From our observations we believe that many of these children who are sent to our reformatories would make better men and women if even this superficial attention were given to them before their commitment by a physician attached to the juvenile court, to be followed up in each instance, according to the opinion of the court, either by the child's natural or rightful guardian, or, should the court deem commitment proper, by the custodian of the municipal or state institution.

"Our suggestions, therefore, would be:

"1. A conscientious routine physical and clinical examination, with recommendations on the case to the court before commitment.

"2. Penalty exacted of the natural guardian in cases of neglect to care for the physical defects of the child or children in his care.

"3. Physical and clinical records kept of each child at time of admission into reformatory, and observations recorded once each month thereafter, or more frequently should the case require it.

"4. Each reformatory attending physician should have as his assistants specialists in the various branches of medicine, as staff officers, to regularly visit and treat cases needing attention in his specialty.

"5. A resident trained nurse.

"6. That the diet and mode of life in an institution be passed upon by that institution's attending physician."

The Pitiable Condition of the Insane in North China. J. H. Ingram, M.D. *China Med. Jour.*, March, 1918, XXXII, No. 2.

Dr. Ingram says that the need of an institution for the insane in China can scarcely be overestimated. The only institution for the care of the insane in China in which modern principles are employed is in Canton. This institution, which is 1,500 miles distant from Peking, is overcrowded, and, moreover, the language difficulty is a great one, for the Cantonese dialect is not understood by people from other parts of China. As the insane are cared for by their families and as the diseased condition of the mind is not understood, they are cruelly treated because regarded as accountable for their actions. Moreover, since a family in China is responsible for the acts of any of its members the family feels compelled to protect itself even by the most inhuman measures.

One case which Dr. Ingram cites is that of a young man who became mentally deranged when about to graduate from one of the mission schools. As suitable provision for caring for him was not available, the patient's father was asked to take charge of him and the father, to protect himself against accountability for his son's actions, drowned him in the river. Another case was that of a man violently insane whose mother had his leg and arm broken in order that he might not be able to terrorize the neighborhood. His sufferings were so great that he managed to commit suicide.

There is a place in Peking sometimes called an asylum for the insane, but, according to Dr. Ingram, it is nothing more or less than a prison where patients are confined and put in chains when necessary, no care being taken for their physical comfort and well-being. At one time Dr. Ingram found that this place was overrun with about one hundred and fifty petty thieves, for whom no other jail accommodations could be found.

The Care of Convalescents in the Ospedale Maggiore of Milan. E. Ronzani. *Osp. Maggiore, Milan*, 1918, V, No. 3.

As early as the sixteenth century the great Milanese hospital set apart certain buildings for the care of the convalescents, but the great number of patients and the lack of funds have always interfered with carrying out an efficient service of this kind. In 1841 the Marquis Secco Commeno donated one million francs to the hospital for the service of convalescents. But little was done at the time until in 1907 Signora Luigia Corti donated another

half million francs for the same purpose. It was then decided to construct two large pavilions for the reception of convalescents, but the erection of the buildings was not carried out until 1916. The two one-story pavilions are built in the barrack style. Each one is 50 meters long and 8 meters wide (about 160 by 26 feet). The floor is of cement and raised 0.7 meters (about 2 inches) above the ground. The walls are of hollow tiles set in cement. A gallery 4 meters wide, intended for heliotherapy, runs along the whole south front of the pavilions. Each building has room for thirty-six beds. The beds are ranged along the two long sides with an ample gangway between the two rows. A physicians' room, a nurses' room, a small kitchen, etc., are at one end of each pavilion. The total costs of both buildings amount to 90,000 francs (\$18,000) or 1250 francs (\$250) per bed.

How to Prescribe Rest and Exercise for Patients with Pulmonary Tuberculosis. M. Ségard. *Jour. de méd. et de chir. prat.*, Paris, 1918, LXXXIX, No. 1.

For patients with active tuberculous processes, rest takes first place as a tonic, antipyretic, and antitoxic. But in the rest treatment two rules must be strictly observed: 1. The patient should always lie down for two hours before the two chief meals and for two hours afterwards. Only thus will digestion and assimilation properly take place and toxic anorexia be avoided. 2. If during any exercise the least rise of temperature is noticed or the pulse rate rises above 100, the exercise should at once be stopped. In English sanatoriums Paterson's treatment by exercise takes, of late years, a prominent place and good results are reported, but we should never forget that the Paterson treatment, in spite of its advantages, is applicable only to patients who show no fever, who are carefully selected, and whose exercises are methodically carried out and supervised.

The Economic Problem of the Italian Hospitals for the Insane. C. Agostini, *Quaderni di psichiatria*, Genoa, 1918, IV, No. 9.

As the Italian hospitals for the insane are very much crowded, they are laboring under financial difficulties. Food being the most important factor in this question, the condition could be remedied by establishing special institutions for the chronic and incurable patients. In this manner, the manicomiums would be given back their true character as hospitals for the cure of mental diseases. Thus the institution would acquire greater dignity and the physicians could better study the nature of the various diseases. The hospitals at Rieti, Spoleto, and Foligno have followed this plan for the last twenty years, and it has proved a success.

The Syphilis Clinic of Emory University, Atlanta, Ga. W. B. Emery. *Am. Jour. Syph.*, St. Louis, 1918, II, No. 1.

The dispensary is open four afternoons each week, Mondays and Wednesdays for women and Tuesdays and Fridays for men. During the months of October and November, 1917, 903 treatments (mercury with injections of the arsenical preparations) were administered. Several assistants act as representatives of the various departments. Those from neurology and pediatrics do especially valuable service, the first being of great assistance in spinal work and the latter in the handling of children. Educating and instructing the patients concerning the nature of their disease forms a special feature of the treatment.



NEW INSTRUMENTS AND EQUIPMENT

VINCENZ MUELLER, Technical Editor.

GEO. W. WALLERICH, Associate Editor.

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast avenue, Oak Park, Illinois.

New Sputum Cup

A new sputum cup, which we believe will be of interest to the superintendents of tuberculosis sanatoriums and hospitals in general, has been devised by Mrs. Bertha M. Logan, superintendent of the Rockford Municipal Tuberculosis Sanitarium, of Rockford, Ill. This seems to be a great improvement over the metal holder and filler cups



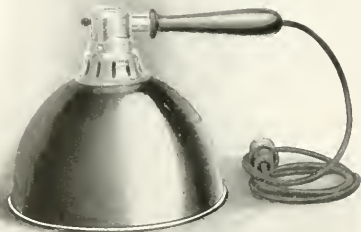
Logan sputum cup.

mostly in use at present, inasmuch as it eliminates the handling and cleaning of holders, also does away with the added cost of the metal holders.

The device is a paraffine cup, absolutely solid, which could remain filled with sputum for forty-eight hours without any sign of softening. It can be dropped in the sack at the bedside of the patient, the sack closed and burned without further handling. This cup will also appeal to the esthetic sense of the patient, as well as of the attendants, since the contents are never exposed to view.

Thermolite Heat and Light Infuser

There are few other methods so efficacious in restoring normal circulation in the body as the application of radiant light and heat rays from a scientifically constructed reflector. The Thermolite here illustrated so directs the rays that when applied over the aching parts they not only affect the surface of the skin, but penetrate deep into the tissues, relaxing the congestion and relieving the pain. It is a simple and practical portable device for convenient application of radiant light and heat where larger and more elaborate apparatus is not available.



Thermolite heat and light infuser.

The Thermolite is a scientifically made instrument, as every detail of its construction has been carefully considered and every underlying principle for correct radiation of heat and the intensity of heat have been thoroughly worked out. The Thermolite rays do not focus; the construction of the reflector is such that the rays are parallel so that all of the light and heat generated by the lamp are thus preserved in their various qualities. The heat rays are effective over an area of approximately 50 square inches and are not focused in a small burning spot, so that the lamp may be used in applications of light for periods of one to two hours in severe cases where such continuous use is necessary.

The Safety Electric Warming Pad

In these days of cheap electric power, now available in the smallest cities, one is always interested in devices which can be electrically operated, and especially if their use tends toward economy. Electrically heated pads have innumerable attractions and are being extensively adopted by hospital superintendents, from the fact that they are clean to handle, require no replenishment of water, as with hot-water bottles, contain no rubber, which will soon deteriorate, and are light in weight. The amount of electricity which the better grades of pads consume is small, so the item of current cost is easily offset by the many conveniences afforded in using an electric pad.

It is not many years ago since the electrically heated pad was considered dangerous, and justly so in some cases. Experience, however, has overcome the faults, and the better grades of pads now made may be considered in every

way safe to use. The "Safety" electric warming pad here illustrated is offered by a manufacturer who has given his product the most careful attention as regards construction. One of the weakest points of construction in the older types of pads was the fact that the pads continued to heat and, with current passing for some time, became too hot, charring the insulation and occasionally doing damage. In this pad an excellent thermostatic switch is used, so that practically any heat from room temperature to about 180 degrees may be had, this temperature being held just at the desired point. To set the temperature it is necessary only to turn a small knob to the heat wanted, when this heat will be exactly held.



Safety electric warming pad.

In an appliance which is handled a great deal it is naturally important that all wiring and heating elements be carefully protected. The "Safety" pad is indeed durably made in this respect. All pulling, bending, or twisting come on a braided copper cable consisting of 72 fine strands of wire. The heating units, or cells, consist of a high-resistance wire wound on India mica, over which are cemented a metal cover. The small units are then stitched between two layers of heavy asbestos cloth. This asbestos cloth is then covered with bags of either eiderdown or cretonne, which can be easily removed for cleaning. Extra covers of waterproof material may also be had.

The pad is very flexible, light, and of a convenient size, 10½ by 12½ inches.

Electric Test-Tube Boiler

The boiler here illustrated consists of a small cylindrical drum, having a nickel-plated metal body with a top and bottom of ¼-inch transite. The dimensions of this drum are: height, 2¼ inches; diameter, 3½ inches. The apparatus is mounted upon three legs.

Located near the center of the drum there is a metal cup or cylinder 1½ inches in diameter and 1½ inches in depth. This is the heating receptacle. The cup is encased in a resistance coil, which provides equal distribution of heat to the entire surface of the receptacle simultaneously, heating it uniformly and very quickly.

This resistance coil or heating unit is controlled by an automatic electrothermo-regulator, contained within the drum. It is adjusted by means of a small screw. To reach the adjusting screw of the thermostat it is necessary to use a small screwdriver. This prevents tampering.

The thermo-regulator completely controls the temperature so that the contents of the test tube may be brought to the boiling point without boiling over. Metal rings are provided for the receptacle, permitting the use of the following sizes of test tubes: ½ inch, ¾ inch, ¾ inch, and 1 inch.

An extra sterilizer attachment, consisting of a container and wire basket, not illustrated, can be attached to the top of the boiler. The wire basket is removed by means of an adjustable wire tong, which fits into loops on the wire basket. Similar loops are attached to the body of the sterilizer, so that the entire apparatus may be easily removed from heated receptacle.

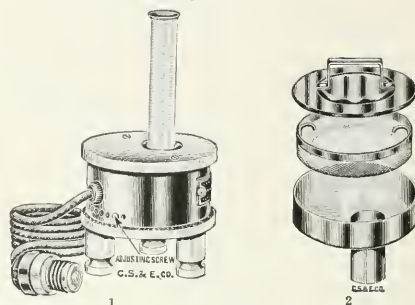


Fig. 1, electric test-tube boiler. Fig. 2, metal rings providing for the sterilization of different sizes of test tubes.

A nest of four test tubes is furnished with the sterilizer, largest one (1 inch in diameter) having a cork disc in the bottom to protect the point of scalpel.

The above-described outfit, in connection with the electric test-tube boiler, makes an ideal small sterilizer for hypodermic syringes and needles, probes, scalpels, etc.

Hot-Air Apparatus

A simple and inexpensive apparatus for the application of dry air of a high temperature has been put on the market by Codman & Shurtleff, Boston, Mass., under the name of "Newell Hot-Air Apparatus." The apparatus is made of sheet iron and lined with asbestos. The sleeves for inclosing the arm, shoulder, leg, and hip are made of heavy



Newell hot-air apparatus.

canvas. The apparatus rests on an iron frame, 19 inches high, the height over all being 31¾ inches. The heat is derived from a kerosene lamp which is supplied with the outfit.

We are informed that a number of these apparatuses have been in use for some time in the orthopedic department of the Carney Hospital in Boston and the Johns Hopkins Hospital in Baltimore, where they are giving satisfactory results.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XI

September, 1918

No. 3

A FRATERNAL INSTITUTION FOR THE FREE TREATMENT OF TUBERCULOSIS

Colorado Sanatorium Maintained by the Modern Woodmen of America for Free Treatment of Tuberculosis Among Members—Progressive Attitude of Society—High Standard Maintained at the Sanatorium

By J. A. RUTLEDGE, M.D., MEDICAL DIRECTOR AND SUPERINTENDENT, MODERN WOODMEN OF AMERICA SANATORIUM, WOODMEN, COLO.

NESTLING at the foot of Mount Cedar, in the heart of the Rockies, the society of Modern Woodmen of America has built one of the grandest monuments to fraternalism that can be found anywhere. The head officers, noting the many deaths due to tuberculosis in their society, conceived the idea of erecting and maintaining an institution for the free treatment of tuberculosis for its beneficiary members.

After duly considering this matter, a committee was sent to investigate the various locations throughout the United States, in order to secure the best possible site for a sanatorium; and the present location, which is twelve miles north of Colorado Springs, was selected. Nineteen hundred acres of land were purchased, and the little town of Woodmen is located there. The population is composed entirely of the patients and those employed by the society to carry on this work.

The sanatorium was officially opened for business on January 1, 1909, although at that time the equipment was very small, consisting of only a few tents and such wooden buildings as were necessary for offices, kitchen, dining-rooms, and

living quarters for the help. Donations from the various camps of the society and from individual members assisted largely in defraying the expenses in the early days of the sanatorium's existence. Later it was maintained on a budget system from the head office, but at the head camp, held in Toledo in June of 1914, the society voted

a special fund for the maintenance of the institution. This fund is raised by a levy of three cents a month on each member of the society; and it is largely due to this fund that the sanatorium has arrived at and maintained its present high standard. Few who visit the institution can realize how so great a work could be accom-

plished in so short a time. The site for the tent cottages was selected and two colonies were formed. At the same time provision was made to increase the capacity so as to accommodate the greatest possible number of patients. In each of these colonies a large utility building was erected, and around these buildings the tent cottages were arranged, ninety in each colony. The utility buildings each contained a physician's office, recreation room, throat room, baths and toilets. The cottages originally had the



Fig. 1. A bird's-eye view of the Modern Woodmen of America Sanatorium at Woodmen, Colo.



Fig. 2. The new receiving hospital, equipped with all the diagnostic and therapeutic devices known to modern medical science.

canvas sides, were heated with stoves and lighted by lamps. However, the sanatorium, after a few years, installed a complete heating system; the cottages were heated by steam and equipped with electric lights. The canvas has been replaced by siding and the cottages have been completely ceiled on the interior, until now they are modern in every way.

Later a large administrative building was erected, containing all of the quarters for executive offices, dining-rooms, kitchen, store rooms, quarters for the female help, library, post office, meat market, barber shop, etc. A home for the

superintendent, cottages for the staff physicians and accommodations for the other help have also been added. Practically all the buildings have been built of the native stone, gathered from the mountains on the sanatorium's estate. A large amount of the ground is now in cultivation, and the institution owns a large herd of Holstein cattle, thus being enabled to maintain its own dairy.

Grading and parking was done, cement walks laid, and the lawns made beautiful with flowers and shrubs. Three large greenhouses are maintained, for the management appreciates the great



Fig. 3. The utility building, with a colony of cottages at one side.

therapeutic value which flowers have in an institution such as this.

Perhaps the greatest improvement the sanatorium has made is the erection of a new receiving hospital, which has been in use a little more than a year. This hospital is equipped with all the devices that modern medical science has to offer in the treatment of tuberculosis. The hospital has a capacity of from fifty to sixty, so that now from two hundred and fifteen to two hundred and thirty patients are being treated at the sana-



Fig. 5. A patient undergoing examination in the x-ray room.



Fig. 4. One of the individual cottages used by patients.

torium at all times. The hospital has complete x-ray and dental departments, operating room, and laboratories. A sun parlor has just been completed on the top of the building, where patients who are compelled to remain in the hospital for any length of time may be taken for recreation and a social hour. Special rooms have also been arranged for heliotherapy.

The superintendent recognizes the great necessity for amusement of a light nature, consequently picture shows are given every Friday evening for the benefit of the patients, lectures by the staff officers each week, and concerts and other amusements are provided by entertainers from Colorado Springs, for the pleasure of both patients and employees. A library of some three thousand volumes is maintained, so that the patients have all the wholesome reading they need. They have their own Sunday School every Sunday morning,

and prayer services on Sunday evening. Twice each month a minister comes to conduct Sunday afternoon services, and on alternating Thursday mornings a Catholic priest from the Springs holds mass for the Catholic patients.

Dr. J. W. White was the first superintendent and medical director of the institution, and he had one assistant. In 1912 he was succeeded by Dr. J. A. Rutledge, of Elgin, Ill., who is still at the head of the institution. As the sanatorium enlarged, the need of more medical assistance became greater, until now Dr. Rutledge has a staff of four physicians and a dentist, and an adequate nursing staff. In fact, the sanatorium has, in its various departments, a complete working force of from one hundred and twenty-five to one hundred and fifty.

Since January 1, 1909, to June 1, 1918, 3,820 patients have been treated at this institution. This number, of course, includes those being treated at the latter date. We have patients living in all parts of the country, many of them returning to lives of active business, and some at this time defending the nation's honor in France. Thorough treatment, including every



Fig. 6. The operating room at the Modern Woodmen of America Sanatorium.

special medical attention one's condition may require, is given, but no patient is permitted to remain at the sanatorium for a period longer than nine months.

The directors of the society and the medical staff of the sanatorium realized that fighting tuberculosis was a long, hard struggle, often a matter of years, rather than months, and in order to benefit the greatest number of the society's members, it would be necessary to limit the time for treatment, rather than to permit patients to remain at the sanatorium indefinitely. They decided to make the sanatorium more of an educational institution, teaching the patients how they must live in order to prolong their own lives, and also how to protect the lives of the people with whom they associate, rendering the greatest assistance toward eventually stamping out tuberculosis.

The patient who discovers his trouble early is almost certain to obtain an arrest of his disease if he comes to the sanatorium at that time. And he is so grateful that he always has a good word for the sanatorium and all connected with it. The patients who come later, when their disease has

become far advanced, seldom receive much lasting benefit.

It is not wide of the mark to say that a sanatorium is a success or a failure, just in the proportion as the patients submit themselves for treatment in early or late stages of the disease. The patients with incipient cases go out in very good condition, happy over the result of their treatment, and with fair prospects to live their allotted time. The far advanced patients, however, very often go home to die, and they and their friends usually feel that sanatorium treatment is at fault. The trouble lies not with the sanatorium, or with the treatment, but at the door of the patient who must remain at home a little longer, to plant his crops, arrange his business affairs, or for some other reason; and in some instances, we regret to say, the fault lies with physicians who do not make the diagnosis soon enough. Could these two defects be eliminated, the work done at the Modern Woodmen of America Sanatorium would be of even greater benefit to the patients and to the society. The work is of inestimable value, for there is no greater law than "Love thy neighbor as thyself."

HOW THE AMERICAN RED CROSS IN FRANCE MENDS MUTILATED FACES

Mrs. Maynard Ladd, the Sculptor, Studies Men's Hearts and Gives Them Back Their Features—Life-like Masks Made of Copper, Painted to Simulate Natural Tones of Skin—Touching Gratitude of Wounded Heroes

BY KATHERINE DE MONCLOS, OF THE AMERICAN RED CROSS.

"A MUSEUM of horrors" is the name by which the hospital for facial wounds is generally known in France. The designation seems a brutal one at first, but when one has been through the wards and seen for oneself, no words can be too strong to express the pitiful hideousness of these mutilated heroes. They are a horror to themselves, to their families, and to their friends, and inevitably their outlook on life has been completely

changed, largely owing to their appearance. It is a difficult problem to place them, and even the public highways are forbidden to them unless

they continue wearing a bandage to hide the gaping hole, the absence of a chin, or the loss of a nose.

In England Captain Derwent Wood [whose work was described in THE MODERN HOSPITAL, August, page 148], has, for some time, been making galvano-plastic masks for these cases. Having seen



FIG. 1. Mrs. Maynard Ladd at work

and recognized the beautiful utility of this work, Mr. Lewis Hind, an English art critic traveling in America, went to see Mrs. Maynard Ladd, the sculptor, in her studio on the North Shore out of Boston. Her versatile talent, her great ability in catching not only the resemblance but the life and personality of her models at once inspired Mr.

tered—but also to gain their confidence. They unconsciously reveal their hearts' very psychology, by which means she is able to impart something of the former expression. The eye is the keynote, and in many instances one or both must be reproduced and the expression, whether gay, pensive, tender, or energetic, is based largely on the knowledge of the inner man which Mrs. Ladd has managed to glean during her friendly chats.

When the molded resemblance is satisfactory, a copper reproduction is made, which is dipped in an electric bath, after which it is carefully adjusted before being silvered. Later it is coated with Aspenwall's enamel and finally painted in oil colors. This painting is no simple matter, for it is treated in a peculiar way so as to obtain the dull, slightly rough appearance of the skin. The nostrils and mouth are open so as to permit breathing, and, thanks to a special cigarette-holder, the men can smoke as freely as before. Where it is necessary to replace the ears, they likewise are perforated so the hearing will not be



Fig. 2. One of Mrs. Ladd's subjects

Hind with the suggestion that she should do for France what Captain Wood is doing for England.

In December, 1917, she came to Paris, took a studio, and started her work of healing hearts as well as mending faces. Her work is done under the direction of the American Red Cross in France.

The man who was ashamed to be seen, who felt his whole life must be spent hiding his hideous wound, had a heart-ache which seemed incurable until Mrs. Ladd offered to make him whole again by replacing the lost face with a new and exact reproduction of the old one. The transformation is complete, for a new hope seems born with the new face; joy once more opens its doors, and the future seems alluringly hopeful to the man restored almost to his former self; he need no longer be a pariah.

Mrs. Ladd's work is almost life-like. When the wound is sufficiently healed, she molds the face, and, with the help of a pre-war photograph of the patient, a portrait is modeled, completely hiding the ravages of the wound. The men are greatly interested in the likeness, and long talks in her studio are of great value to the artist, for they not only help her to rectify the profile, which is not always a perfect resemblance—sometimes the nose must be lengthened or the chin slightly al-



Fig. 3. The completed work

hampered. Mustaches are sewn in. Artificial eyes are not inserted, but false eyes are modeled in plaster. A complete mask covering all the face costs only eighteen dollars; the half mask costs nine dollars. Mrs. Ladd is taking nothing for her services, which accounts for the low price at which this artistic work has been established.

Owing to war difficulties, the work does not progress very rapidly; it takes about a month to execute a complete mask. The mask is extremely light and strong, is generally held on by means of spectacles fastened back of the ears, and so firmly and comfortably is it attached that the wearer takes childish pleasure in pulling and stroking

his mustaches while sauntering down the street, a cigarette between his lips. The illusion is pathetically amusing.

The American Red Cross is having a certain number of masks made at its expense. The first hospital to order any—and it still shows a deep interest in the work—is the French Military Hospital, the Val de Grâce. The Lariboisière Hospital and the Belgian and Mutilé Hospitals at Rennes have also recently appealed to Mrs. Ladd, and most of the surgeons are much interested in the work. Dr. Tait McKenzie is starting a deposit school in Philadelphia; so on all sides the good work is spreading, and soon hundreds will be able to profit by this pioneer movement.

The men are touchingly grateful. A tall handsome fellow came back to the studio after his first outing, overjoyed; it was the first time in two years that he had not been stared at in the

streets in horror. Another good-looking country lad, if one could believe his former photograph, laughed delightedly when the completed mask was finally adjusted. "When I go home," he said, "I'll have all the pretty village girls hanging around my neck wanting to kiss me, I am so good-looking!"

Mrs. Ladd has sculptured an infinitely touching figure of one of these mutilated heroes. To her he symbolizes the moral attitude of all who have sought her help. He is kneeling, seated back on his heels. His hanging upturned palms, seeming to appeal for pity and assistance, the defeated droop of the shoulders, the bowed head, as though ashamed of showing the death mask, all that is left of his former face, are a heart-breaking appeal, and speak more eloquently than any words of the hopelessness and sorrow which so often accompany these disfiguring wounds.

HEALTH INSURANCE: ITS MEDICAL AND HOSPITAL ASPECTS*

What Its Benefits Really Are—An Insurance Plan Which Penalizes Neglect and Rewards Prudence—Prevention a Function of Social Insurance

BY JOHN A. LAPP, DIRECTOR OF INVESTIGATIONS, HEALTH AND OLD AGE INSURANCE COMMISSION OF OHIO

AMONG the major hazards of life, sickness is one of the most important. Indeed, it would be voted as the most important hazard by any group of people. "If I can keep my health, I am all right," is heard on every side from those who toil for a living. The misery in the home of the people of meager means, when disabling sickness enters, is beyond description. It need not be described, however, because everyone has seen it. A sort of fatalism possesses most people, and their fear of disease is expressed in their hopes that they may be spared. Yet they know that, unerringly, a certain number are doomed to sickness and death every year, every day, and every hour, and it is only a question as to whose turn is next. So unerring is the law of sickness and death that we can tell, almost to an exactitude, how many people will die next year, and about as exactly how many will be sick, and for how long a time.

Sickness leaves in its train a variety of consequences besides its major consequence—death. A part of the afflicted are disabled permanently and incapacitated from earning a living. Another part are partially disabled and thus physically handicapped. Another part are handicapped economically by the cost of sickness and the loss of earnings. A large number are driven to dependence by their unpreparedness for a severe

sickness and by the consequent necessity of relying first upon relatives, then upon friends, and finally upon the public. Any one of these consequences may happen to almost any person. Even the accumulation of a "nest egg for a rainy day" will not suffice to save the most thrifty from the hazard. A man who may be considered well-to-do in the world's goods, may, as a result of a single prolonged sickness, be placed in a position of economic dependence. Not one per cent of the people of Ohio are possessed of enough property to insure them against dependency, if they should be stricken with a prolonged disabling sickness.

Under such circumstances, life is a gamble, and the stakes are nothing short of all we hold dear. We do not even have the privilege of throwing the dice. We cannot even verify the result, and from the verdict there is no appeal. We accept the consequences and call it fate.

Fourteen in every thousand of Ohio's population, or about 70,000 in all, will die this year. From 2.5 to 3 per cent of the total population will be seriously sick at all times, or 125,000 to 150,000 people, and the number of different persons who will be sick will number from 2,000,000 to 2,500,000. Those who are sick, roughly speaking, will average about eighteen to twenty days' of disability. Of the 125,000 to 150,000 who are sick at all times, about 12,000 to 15,000 will be sick for less than seven days, while from 60,000

*Read at the Fourth Annual Meeting of the Ohio Hospital Association, Columbus.

to 75,000 will be sick more than three months, and this excludes the dependents in county infirmaries and state institutions. There are, today, in Ohio, fully 25,000 people, outside of charitable institutions, who have been sick for more than three years.

Facts such as these were the reasons which impelled the last General Assembly of Ohio to create a special commission to investigate the causes of sickness, and to determine whether a plan of health insurance could be organized, under state auspices, which would distribute the cost of sickness, eliminate so far as possible the gamble of life, and thus stabilize society. The commission has been at work for several months in an earnest effort to find out the facts about the extent of sickness which are needed as a basis for an understanding of the problem and for constructive proposals to solve it.

First: To begin with, a commission of this kind should determine whether or not there is a condition demanding legislative action. If the commission finds there is not such a condition, then it should proceed no further, for it is unwise to attempt to cure non-existent ills by placing unnecessary laws upon the statute books.

If the commission finds the conditions do demand correction, then it should measure and consider what the actual conditions are. The very fact that a commission is created for the study of a subject presupposes that enough information is at hand to show that conditions demand action, or, at least, warrant action for the public welfare. It is hardly conceivable that the legislature would create a commission to study a subject and provide any considerable appropriation therefor, unless there are conditions which are so evident as to warrant the expenditure, and unless the problem is so difficult as to require the services of a special commission. We must assume, then, that the evidence would warrant the conclusion that a definite need is presented.

Second: Having measured and considered the existing need for legislation or action of some kind, the commission's next step is logically to determine what existing laws or agencies there are already to meet the needs, and how well they are meeting them. They must go further and see whether the existing laws and agencies may not be so corrected, revised, or enlarged as to meet the needs. If this is done, and it appears that present laws and agencies cannot be made adequate, then the next step logically follows:

Third: Remembering that "there is nothing that is new under the sun," the commission will try to determine what other states and other countries have done to meet similar conditions, for it

is very certain that no subjects are proposed in modern legislation which have not somewhere received legislative attention. Legislative investigators will tell you that they scarcely ever have a proposal without some precedent. Andrew Carnegie once said that his company had lost many millions of dollars by undertaking things without first knowing the whole experience of the industry on that subject throughout the world. It is very safe to say that the people of the states have spent billions in unwise experiments which could easily have been prevented by attention to established facts.

Fourth: Along with a study of legislative experience goes the collection of information, data, and opinions expressed by publicists and administrators, so that the actual operation of laws and their administration may be fully and carefully weighed. It is unnecessary to say that the mere presence of laws upon the statute books does not indicate that they are accomplishing what they were designed to accomplish. Nothing but a study of administrative experience under such laws will warrant final conclusions.

Fifth: A study of administrative experience is essential also in determining how any proposed plan will fit the local conditions and the machinery of administration in the state in which it is to be put in force. Detailed studies are extremely important. The very last point of administration must be determined, or else the structure, otherwise admirable, may not stand the test on account of defects in detail.

Sixth: If legislation is proposed and costs involved, it is very important that the extent of costs and the source from which the money is to come should be determined. In general, the question of costs must be considered (because it is a practical problem); yet, actually, when the evidence shows that a thing must be done to meet an established social need, this side of the question must, to a certain degree, be shoved into the background, because society must do the thing for which it is responsible, regardless of cost.

Seventh: Commissions naturally desire to see their work result in some action. Non-action condemns the fruits of their investigations. If, after studying a subject for two years, it is the plain and clear conclusion of a commission that conditions cry out for action, and the legislature should then fail to enact laws to meet those conditions, the commission must consider that its conclusions have not been so well founded as they supposed, or else that it has not been able to express them convincingly enough to cause action to be taken. Probably one of the greatest sources of weakness and causes of failure in the work of the legislative

commissions is that proposals are not worked out in final details in the form of legislative bills. The framing of the bill to carry out exhaustive and detailed recommendations is the most difficult of all the processes, and failure to prepare the bill leaves a burden upon the legislature which it is unlikely to perform as thoroughly as if the definite bill is laid before them for consideration.

The Ohio commission has approached the problem with unanimity of opinion on one point, namely, that the problems entrusted to it are the most important which have ever been considered by a commission or by an American legislature. Naturally, therefore, there has been an unanimity of opinion that no effort should be spared to uncover all of the facts and present them without bias. I can speak truly for the commission that not a single member would favor action of any kind which did not find support in the facts disclosed. The members realize that the issue is too important, and the consequences too vital to the social and economic welfare of the state, to warrant action upon anything less than the whole truth.

Health insurance should provide two main benefits to cover the corresponding hazard:

1. Cash benefits to be paid during disability.

2. Medical benefits, including care by physicians, nurses, hospitals and dispensaries, and the cost of medicines.

Both of these elements are essential to any adequate solution of health insurance, but, if one is more essential than the other, that one is medical benefits. The commission finds that in existing health insurance in the state, cash benefits are provided for to some extent, the prevailing benefit being from \$5 to \$7 a week, while complete medical benefits are almost unknown. Even the cash benefits stop at the end of thirteen to twenty-six weeks, in most cases.

Now, if health insurance is to be real insurance, it must cover the whole risk, and be for the whole time. Mere insurance, of a fraction of the wages of a man for twenty-six weeks, will not insure that man against the hazard of sickness. To be really insured, a man must be secured against the loss of, at least, a large part of his wages during the entire time of his disability, and also against the cost of adequate medical care, whether that cost be ten dollars or ten hundred dollars. The real cost of a serious and prolonged sickness is more in the medical, hospital, and nursing care than in the loss of wages, although the loss of wages must not be overlooked by any means.

Let us see what happens in cases of sickness in typical homes.

A. A man with a family of four, earning \$18

a week and insured for \$7 a week, with no medical benefit, is taken sick with typhoid fever. The man has no savings. If there is a city or charity hospital, the man may accept public relief and be cared for in the hospital. If there is no such hospital, or if the man desires to be independent of relief, a physician is employed to care for him in the home, or the hospital takes him as a pay patient. If he pays either for hospital care or home doctoring, he will find that, at the end of his sickness, he has a debt for medical care which he cannot hope to pay out of \$18 a week. In the meantime, his family has been compelled to pay rent and live on \$7 a week, as against a normal \$18 a week. Even if medical care is given free in a hospital, the man will still find a debt, for the necessities of life for his family are so large that he cannot but be discouraged to face his old problems of living and his new problems of paying a just debt on \$18 a week. He is apt to leave the hospital and return to work before he should, and a relapse may bring him back, to add new burdens and to sink him deeper in debt. Meanwhile, the worries for the future hinder his return to health. This man has been weakened, economically to the breaking point, if, indeed, he is not broken. Another sickness in his family will compel him to ask for charity.

B. This man has a wife and two children, earns \$22 a week, and owns a home worth \$3,000, which he has paid for by the savings of fifteen years. He has health insurance of \$9 a week in a fraternal order, for a period of thirteen weeks' disability. He is stricken with a disease which lays him up for six months and requires the constant care of a nurse and two visits a day from the physician. If he pays his bill at the regular rates and the deficit in the family income, he will be in debt upwards of possibly \$2,000. His home may be sacrificed, or he may spend fifteen years more in saving to make up the deficit. Another prolonged illness, and even this thrifty man, who had saved \$3,000, would have to ask the public for relief.

C. This case is similar to Case B, but this man had \$10,000 in property, and no insurance. A partial stroke of paralysis rendered him practically helpless for ten years, and required constant medical care. His entire fortune was spent, and, in his weakened condition, he had to begin life over.

Let us now assume a case under a health insurance plan which provided adequate medical care and gave cash benefits. A man with a family of three has savings of \$1,000. He is taken sick with a puzzling malady. The home doctor is uncertain, and has the case given to a local hospital. The

hospital doctors give the case a searching diagnosis, and find that an operation of great delicacy must be performed. The patient is removed to one of the leading hospitals of the state, and the operation is performed by an eminent specialist. The patient slowly recovers, and in six months' time is finally restored to health. But what has happened in the meantime to his economic status? The sickness insurance has been nearly enough to pay the living expenses of the family. They have drawn upon the savings to the extent of \$100. There are no doctor bills, and the man begins life almost where he left off, with no great economic handicap. If he had not had the cash benefit he would still have \$500 of his savings left, but if he had not had the medical benefits he would either have died from inability to purchase what he needed or he would have been behind not less than \$2,000, when he was again ready to go to work.

The point in these cases is not to prove the value or necessity of health insurance, but, rather, to point out the relative importance of medical benefits, including complete hospital care and treatment. At present, in some parts of the state, such care is available to the poor who accept it as a charity; to the semi-poor who accept it as a semi-charity—a part-pay proposition; and to the well-to-do who pay liberally for it. In other parts of the state, such care is available to neither the rich nor the poor, and facilities are not available to bring patients from smaller places to the centers where hospital facilities abound.

If the foregoing appears as an argument for health insurance, it should be remembered that no one doubts the value of such insurance. It is accepted and approved by all people, just as fire, life, and accident insurance are accepted and approved by all. The only question at issue is whether health insurance can be and should be organized by the state on a universal compulsory basis. That is the question which the Ohio commission considers its duty to solve. The Ohio commission is prepared to express no opinion at this time, but, in conformity with its policy of open discussion, it is frank to say that any plan of health insurance, to get its approval, must provide adequately for medical and hospital care, so as to cover the whole risk, and for the fullest possible development of preventive measures.

To all persons who are impressed by the evidences of ill health and disability, as disclosed by the figures of the first draft, by the partial sickness surveys which have been made, or by common observation, it must appear that correction and prevention are of the first importance. We do not know exactly what part of the disabilities, as shown by the draft, could have been or could

now be corrected, nor do we know exactly what part of the average daily sickness could be prevented, but we do know that, in each case, the percentage is very high.

The relation, therefore, of health insurance to sickness prevention needs the most careful study. If health insurance will provide for the cost of adequate medical, hospital, and nursing care, while at the same time tiding the individual over the loss of wages, then corrective and preventive measures can be applied. If health insurance will not fit into the scheme of prevention, then the argument for it as a social measure is weakened.

Prevention can best be accomplished in an insurance plan by putting a money premium upon it. The city or town which fails to promote the health of its people should be charged extra for its neglect; the industry which weakens the vitality of its workers by insanitary conditions, should be penalized; and the worker who dopes himself with drugs or liquor should get smaller benefits or pay an extra price. On the positive side, a premium should be placed upon approved conditions in factories and in cities, to the end that if minimum health standards are maintained, or if preventive measures, medical care, and other facilities are furnished, a reduction will be made in the cost. Good sanitary conditions in industries and municipalities should be rewarded, as well as bad ones penalized. Trade unions, fraternal societies, and establishment funds should be encouraged to reduce as far as possible, the burden of preventable sickness.

The state is concerned primarily with the whole social cost of insurance. That cost is the total loss from sickness, and not merely the amount paid out for losses. The social motive added to the economic motive makes prevention a fundamental in health insurance by the state. Health insurance by private companies is not concerned as a business proposition with the prevention of disease. It measures the probable loss from sickness, and fixes its premium accordingly. State health insurance, on the other hand, should prevent all preventable sickness as a social policy, and health insurance organized by the state should provide the most complete plan for the prevention of disease. As a social institution, the state cannot do less, because, to quote that great medical leader Dr. Victor Vaughn, "That government is the best which secures for its citizens the greatest freedom from disease, the highest degree of health, and the longest life, and that people which most fully secures the enjoyment of these things will dominate the world."

Prevention is not a function of insurance when conducted by private corporations. It is a func-

tion of any plan of social insurance. Private fire, life and accident insurance companies distribute losses, but do not necessarily prevent them. The more the losses, the higher the rates. It is merely a matter of adjustment of rates to losses. The state and other carriers of insurance, under a state social insurance plan, should be encouraged to develop preventive measures. The commission is asking that the best thought of the state undertake to help make prevention of disease effective, if some plan of social health insurance should be approved by it.

On the corrective side, a great new movement is in progress as a result of our awakening due to the war. We have come to appreciate the value of man-power and to give a thought to human salvage. We are taking steps to rehabilitate the wounded and disabled soldiers and return them to self-support and independence, and perforce we shall inevitably turn our attention to the men who are handicapped in industry by accident and disease. We have seen the handicapped man on the street, in the factories, in almshouses, everywhere, but we have not seemed to realize that he constitutes one of the greatest social problems for democracy to solve, namely, the removal of the handicap, so far as it may be removed, and the refitting of the man to take his place in the world's work.

Suddenly, when the war was precipitated, we began to think what should be done for the men who suffer physical handicaps as the result of wounds or disease in the army.

Our neighbor, Canada, offered examples of the solution of the problem. Her rehabilitation work had been done to remove, as far as possible, the physical handicaps of the returned men, and to fit them vocationally for effective labor. Our experts visited Canada, saw the results, and came back enthusiastic over the program for physical and vocational rehabilitation of wounded soldiers. A bill is now pending in Congress, with every certainty of passing, making a large appropriation of money for the conduct of the work. It is a great humanitarian and socially constructive movement. But the question is asked, "Why confine it to the soldiers of the field and not make the same principle apply to the soldiers of industry who are wounded and crippled by the thousands in the factories, or on the streets of our country?" It is strange indeed that we have not thought of the problem before, but we are fortunate now in at least having the naked truth before us and in having examples of the solution of similar problems right at hand.

No action is likely to be taken by Congress at this time, with reference to industrial cripples,

but their rehabilitation is bound to follow in the wake of the rehabilitation work among the soldiers. It ought to have been adopted in the states as a part of the Workmen's Compensation Acts, but it was not, and serious consequences have followed. No system of workmen's compensation can be permanently successful as a social institution without adequate rehabilitation work, and no health insurance plan can ever be successful as a social institution, unless provision is made for the men who are handicapped by illness or physical defects. In this work the hospitals must play the largest and most important part.

It appears, from the foregoing suggestions and facts, that the rehabilitation work now in progress and in prospect will place new and, I take it, altogether acceptable duties upon the hospitals. Health insurance would bring further needs for the hospitals to meet, and, at any rate, the preventive and corrective measures which are bound to come, either with or without health insurance, make necessary the expansion of hospital facilities. It is probable that, owing to lack of organization to serve all classes, not one-half of those who need hospital treatment actually go to hospitals, even in cities where ample facilities are at present furnished. If the whole state were properly provided with hospital and dispensary facilities, properly organized, there would be fully four times as many cases cared for as at present. Health insurance would, of course, greatly increase the demand.

How to organize a state-wide hospital service is a problem which needs to be carefully considered, whether health insurance is provided or not. I am indebted to Dr. A. R. Warner, of the Ohio commission, for the suggestion—which I hope he will elaborate further—that state hospital facilities might be organized on the plan of the military hospitals in the war. At every county-seat, or at the population center of each county, there should be an emergency hospital with dispensary and ambulance facilities of sufficient equipment to give emergency relief, or, if possible, to take care of the less serious cases, and especially of maternity cases. There is surely no county in the state which cannot provide this minimum. At the larger centers the base hospitals are provided, to which patients needing more extended treatment are removed. At the centers of population, where hospital facilities already abound, there would be the splendid hospitals in which difficult diagnoses could be made and delicate operations performed, or treatment given. Dispensaries and clinics could readily be furnished locally and at the base hospitals. Under

this plan, a person taken sick in the remote country town has the chance, if he desires it, to obtain the best medical and hospital care which the state affords, within his reach. Under a health insurance plan which carries the whole risk this would

be given to the insured, in the language of the jurist, "freely and without purchase, completely and without denial, speedily and without delay," the service being paid for out of the insurance funds.

HOW TO BUILD AN EFFICIENT GENERAL HOSPITAL FOR A SMALL COMMUNITY

A Typical American City of Four Thousand—How Brookville is Solving Its Hospital Problem—Some of the Questions To Be Asked Before Planning a Hospital

By EMMET E. BAILEY, ARCHITECT, PITTSBURGH, PA.

THE Brookville General Hospital is to be built in a typical small city of about four thousand people. Among the industrial activities of the community are manufacturing and mining. There are two railroads running through Brookville, and it is surrounded by a good farming country. So it will be seen that there is nothing unusual about the place, and whatever would apply to Brookville would apply to the average town of its size anywhere. I think it is true that that board of trustees are a little above the average board of trustees, in both harmony and general business ability, the value of which is obvious in a new building project. So far as the place itself is concerned, its people are afflicted with the usual ills that flesh is heir to, with about an average proportion of each. The solution of the hospital problem in Brookville, therefore, should help to answer the question how to build a complete, modern, efficient, general hospital in a city of four thousand with the money available.

In the first place, the cubic foot costs for all buildings of a certain class are fairly uniform, with some variations according to locality. I am a firm believer in fireproof hospital buildings, simple in design and with an interior detail specially suited for hospital buildings. I am convinced that such a building will cost not less than thirty-five cents a cubic foot. Now, if we have say forty thousand dollars to spend on the building, complete, it means that the building must not contain over 114,000 cubic feet. We must remember that every one of those 114,000 cubic feet cost thirty-five cents and must not be wasted, but every foot must be placed where it will be doing full duty all the time. If the building is a two-story building with a ten-foot ground story, it will probably be thirty-one feet high, which means that we must confine ourselves to not over thirty-eight hundred square feet of ground.

In the next place there are at least three classes of citizens vitally interested in the building of a general hospital building, viz:—physicians,

nurses, and the public. The physician is entitled to an institution, including the building, which lends itself in every way to his work of ministrations to the afflicted. The nurse is entitled to a plant so arranged and equipped as to conserve every ounce of energy possible, consistent with efficient service, to the end that the patient may be better cared for and the nurse enabled to continue the service. The public is entitled to an institution that never says no to a sufferer. If, in the effort to keep the cost down, any one of these three interests is neglected, the institution will never be able to do the efficient work that it ought to do, for it will be out of balance.

In my investigations of general hospitals, I have sought to learn of the things in use which were not spoken of at all, realizing that it is the shoe that hurts which attracts most attention. There are things, of course, that jump up and slap you in the face, as you enter the building, which are radically wrong. There are also those features being used in almost every hospital which are filling their place after a fashion, but which, like the shoe that hurts, cause a limp in the work, and for that reason are thought of more than some other features of the building, which are so harmonious in their appointed functions that they are not noticed at all.

I believe that the study of a general hospital should be started by first scheduling and charting the entire service, forgetting, for the time, that there are any limitations in money, and listing everything that would unquestionably contribute to the work of an institution of this kind. When every room is listed and the work to be done in it, its size and approximate location are charted, then start the drawings. If the matter has been studied thoroughly, in preparing the list and schedule of requirements, about the first thing discovered when work on the drawings is begun, is that there are about three times as many requirements as it is possible for the building to accommodate. This should offer no discouragement.

ment whatever, for it is a sign that we are on the right track and, so far as it goes, is an indication that the effort will result in a building containing a minimum of "misfits" and "forgotten" features. From this point on it is a process of "boiling down," never forgetting that, in combining several rooms in one, provision must be made for the work in the one that would otherwise have been done in several rooms. It must

questions on this list for the purpose of illustrating the method:

1. May patients be taken from the ambulance to the delivery room or to the operating room without going past wards or private rooms?
2. Is the lighting in the operating room from the north or from above?
3. What provision is made for bathing and examination of incoming patients?

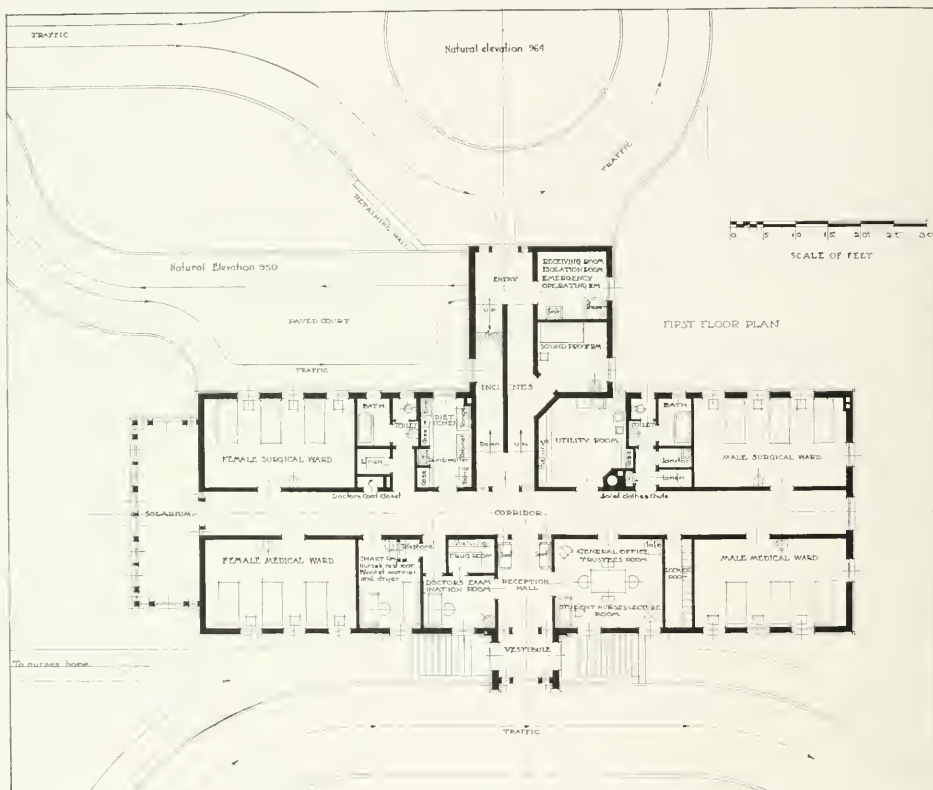


Fig. 1. First floor plan of the Brookville General Hospital.

ever be borne in mind that, while the number of patients in a small hospital is less than that in the large hospital, nevertheless, the variety of ailments, generally speaking, is all there, and, as I have said, each building must be so studied that it develops a maximum of efficiency, both for the physicians and for the nurses, in the work of relieving and caring for these patients.

In developing the General Hospital for Brookville, floor plans of which are shown, we prepared a list of questions which were to be satisfactorily answered by the plan. I will give a few of the

4. Is there an isolation room for suspicious cases?

5. Is there a sound-proof room for delirious patients?

6. Is provision made for isolation of venereal diseases?

7. What provision is made for care of patients' clothing?

8. Where will the food for convalescent patients be prepared and served?

9. Is there room provided for distinct service for obstetrical cases?

10. Is space provided for nurses' office?
11. Is there a convenient place for a blanket warmer provided?
12. Are there service rooms, equipment and utility closets?
13. Is there sufficient space for linen storage?

17. Have the doctors a consulting room near the reception room?
18. Is space for x-ray rooms ample?
19. Are provisions made for a laboratory and drug storage on the ground floor?
20. Are diet kitchens so situated that food can

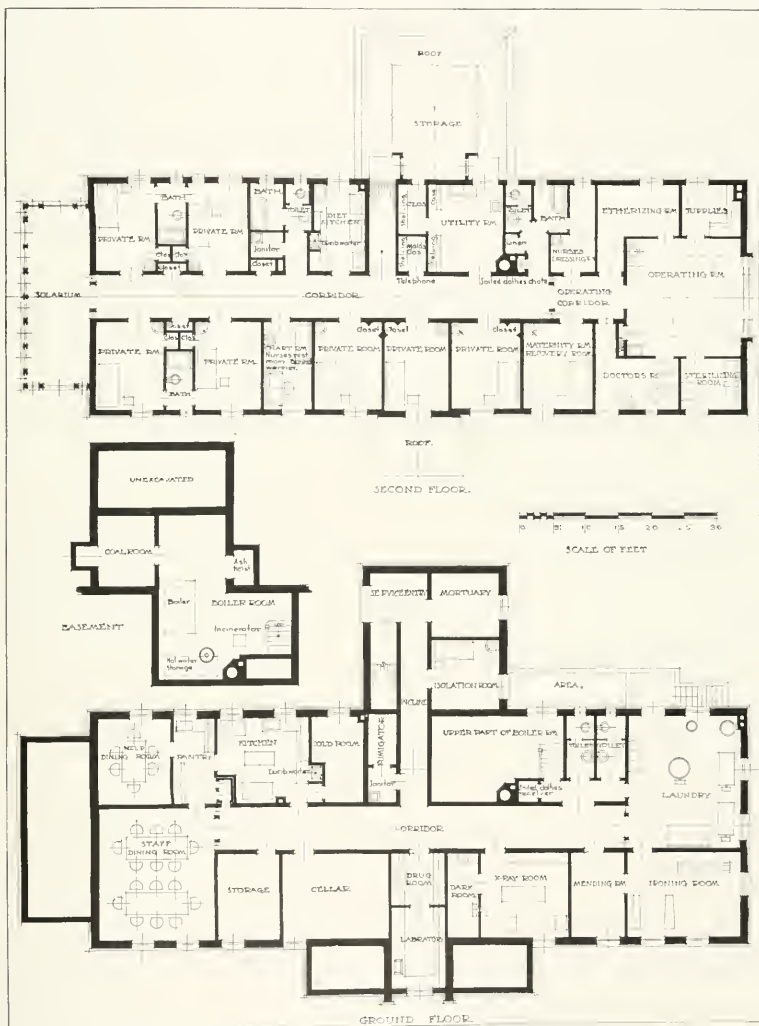


Fig. 2. Ground floor and second floor plans of Brookville General Hospital.

14. Are provisions made for a lecture and demonstration room for student nurses?
15. Is a silent signal call system provided for?
16. Is there a private telephone booth on each floor convenient for visitors and nurses?

- be prepared in the main kitchen and taken to the diet kitchens in the dumb waiter?
21. Does the equipment include provision for an incinerator and a disinfecting room?
22. Should an emergency patient require atten-

tion when both the operating and maternity rooms are in use, where will such a patient be taken?

23. Is there an autopsy room located on the ground floor in suitable place?

24. Is there a place in the basement where apparatus can be stored, when not in use, and where it can be repaired?

25. Is the sun porch sufficiently large, and is it on the south side of the building?

26. May patients occupy private rooms and use the sun porch at the same time that ward patients do and be entirely separate?

27. How are patients to be conveyed from floor to floor?

28. May a bed be taken out of one room, run along the corridor and into another room without difficulty?

29. Is there a place in every private room for a bed without placing it in front of a window?

30. May the building be properly ventilated without exposing patients to a draft?

I am fully aware that much has yet to be learned about planning a small hospital before a perfect one can be built, but I believe we have in this structure eliminated at least some of the mistakes common in small hospitals. The exterior of the Brookville Hospital is stucco on hollow tile. The floor construction is hollow tile with concrete joists. It is plastered with lime and sand plaster, principally because this produces a more nearly sound-proof building than hard wall plaster does. The flooring in all the corridors, operating rooms, kitchens, and bathrooms, is marbleoid with a sanitary base. All angles at the ceiling line are formed with a cove. All windows are provided with anti-draft side pivots and are hung on brass chains and weights. The building is heated with a two-pipe, vacu-vapor, modulating system. Inclines are used throughout the building instead of stairs.

The nurses are housed in a separate building, which was formerly a dwelling. This has been purchased by the board of trustees and will be prepared for the nurses' use.

I can not express myself too strongly on the importance of beginning preparations for a small hospital by first considering every possible convenience, so many of them, that if all these needed conveniences were installed, the building would cost four times as much as the available funds would provide. When this is done and the building "boiled down," remembering the doctors, the nurses, and the public equally, we usually have pretty nearly every exigency provided for, and, while one room may be called upon to serve for

three or four rooms, everything has been thought of. Then, if we don't fool ourselves as to cost, but act on our good judgment instead, and bring the building down to a size where we know it can be built for the means available, we shall be surprised and pleased to note what can be accomplished even in these strenuous war times. If, on the other hand, we do fool ourselves, and take a chance, thinking that perhaps we can get under the wire with the cost, then find we can not, and, to get the job to go ahead, make some radical and unreasonable cuts, we simply destroy the symmetry of the plant and impair its usefulness for all time.

If there ever was a time for serious thought and profound study on the part of those designing and planning small hospitals for such communities as I have suggested, it is now. So many physicians and nurses and other employees are going into the service, and so many wounded men will be returning from the service, that means for the treatment of all kinds of cases in hospitals must receive much more attention than it has ever received in the past. The time has come when the energy of the physician must be conserved and provisions made for making the most of his time.

Red Cross Work in India

"Following the example of the parent order, the St. John Ambulance Association in India affiliated itself in August, 1916, to the Joint War Committee in England under the title of the Indian Branch of the Joint War Committee of the Order of St. John and the British Red Cross Society. Whilst leaving untouched the civil side of the St. John Ambulance Association, the amalgamation has promoted efficiency as regards Red Cross work, as the first annual report of the activities of the Indian committee testified. Six hundred and forty-five nurses and nursing orderlies have been provided, while a further demand for one hundred nurses is being met. A total of 113 motor ambulances, charabancs, and touring cars has been supplied, and 22 launches for Mesopotamia, including two mobile laboratories, one of which is fitted with special bacteriological equipment. The committee also undertakes the upkeep of the Lady Chelmsford Special Red Cross X-Ray and Electro-therapeutic Hospital at Dehra Dun. Red Cross representatives have been appointed at the headquarters of each division, divisional area, and independent brigade in order that the demands for Red Cross comforts may be readily complied with, and military hospitals are now as far as possible supplied by the local working centers instead of having to rely on the Red Cross depot at Bombay for their requirements. The various Red Cross organizations throughout India, including Burma, have been for the most part amalgamated with the Joint War Committee, and are now working in conjunction with it."—Lancet.

"The great p'int about gittin' on in life is bein' able to cope with your head-winds. Any fool can run before a fair breeze, but I tell ye a good seaman is one that gets the best out o' his disadvantages."—Sarah Orne Jewett.

SOME PROBLEMS OF HOSPITAL MANAGEMENT

**Louisville City Hospital Solves the Intern Problem by Employing Senior Students—
Venereal Clinics Held with Active Assistance of United States Public Health
Service—Affiliation of Large and Small Hospitals Desirable in
Training Nurses—Splendid Work in Conservation**

BY HENRY ENOS TULEY, M.D., F.A.C.P., SUPERINTENDENT, LOUISVILLE CITY HOSPITAL, LOUISVILLE, KY.

THAT the ideal hospital is the teaching hospital is conceded by all leading authorities in hospital management. The following reasons, advanced by Dr. Harold C. Goodwin, superintendent of the Albany Hospital,¹ sum up the advantages of a teaching hospital: first, to the patient, because of the complete equipment such a plant provides; second, to the attending men, who must keep to the front or be superseded; third, to the interns, who are fortunate enough to secure an appointment; fourth, to the student body, which is allowed the freedom of the hospital; fifth, to the training-school for nurses, which always has before it the examples of well-trained men doing careful work; sixth, to the surrounding community, which, as a result, has a higher standard of practicing physicians in its midst; seventh, to the physicians in the surrounding country, who are able to see, in consultation and otherwise, the best men in their respective specialties; and eighth, to science, because in the teaching hospitals new therapeutic and diagnostic methods can be studied, by means of its trained clinicians and laboratory workers, which can not be done in the non-teaching hospital, since the latter has neither the properly qualified staff nor the equipment.

Hospital administration may be subdivided for consideration into (1) administration proper; (2) engineering; (3) intern staff; (4) nursing; (5) laboratory; (6) laundry; (7) kitchen; (8) bakery; (9) housekeeping; (10) out-patient department; (11) visiting staff.

I. ADMINISTRATION

This includes statistical department, accounting, pay roll, supply requisitions, telephones, and information.

The average visitor to the hospital has but little conception of the details in the office of the large general hospital. Here are grouped the daily statistical reports, admissions, discharges, and deaths. Vital statistics must be made to conform to the International List of Causes of Death, or they are returned by the Census Bureau for modification or amplification. A complete cross-index system of causes of death will shortly be installed in order that the statistics of the hos-

pital may be readily available. Here all histories are assembled and the many which are incomplete are returned to the intern for completion of histories and physical findings. Day-books in all departments must be carefully kept for the pay roll, which is made twice each month. The present administration in many city departments has arranged weekly payment of wages, thus doing away with the claim shaving in vogue for so many years whereby 5 percent was paid to private brokers who advanced money for wages before the city pay rolls were authorized. The supply pay roll must be carefully audited, bills checked and attached to duplicate requisitions, and the totals must agree with the city buyer's office and the Board of Public Safety. The telephone board must be carefully, intelligently, and courteously attended, and ambulance calls properly scheduled and recorded. An average of 1,200 calls are received daily over the telephones—inquiries regarding patients, staff calls, house messages, etc.

The present bookkeeping system of the hospital is not at all satisfactory, as the various subdivisions of accounts do not give sufficient details of cost to be of value in keeping an accurate departmental cost. These can well be divided into the following ledger accounts.

1. Ambulance: Gasoline, supplies, oil, repairs.
2. Bakery: Flour, yeast, coke, supplies.
3. Drug Store: Medical supplies, serum, alcohol, wines and liquors, cotton and adhesive, supplies.
4. Grocery: Fresh meats, lard and smoked meats, butter, sugar, tea and coffee, cereals, condiments, milk and cream, eggs, fresh meats, canned and fresh fruits, fresh vegetables, canned and dried vegetables, groceries, miscellaneous.
5. Housekeeping: Brooms and mops, buckets, soap, scrubbing powder, supplies.
6. Laboratory.
7. Laundry: Soap, starch, washing powder, washing soda, supplies, repairs.
8. Matron: China and glassware, linen, rubber goods, thermometers, surgical dressings, hospital supplies.
9. Operating Room: Ether, gas and oxygen, catgut, etc., supplies, repairs.

¹THE MODERN HOSPITAL, January, 1918, p. 33.

10. Office: Printing, stationery, telephone, miscellaneous.

11. Power House: Fuel, light, oil and grease, gas, machine supplies, repairs, ice plant.

12. Repairs to Building: Hardware, plumbing, carpenter supplies, painter supplies, plaster.

13. Training School for Nurses.

14. X-Ray.

15. Miscellaneous.

16. Permanent Improvements: Buildings, bet-terments, furniture and fixtures, automobiles.

II. ENGINEERING

This includes maintenance of the power plant in the most economical manner, handling and storing of coal, light, heat, and sterilizing plants, ice manufacture, and repairs.

The engineering department might be considered the heart of the hospital. The economical running of this department is essential. Abnormal cost of coal, such as was experienced during the past winter, makes it impossible to operate the hospital within the estimated cost of the annual appropriation. One item alone for the hospital, coal, from September 1, 1916, to March 1, 1917, cost the city \$8,923.26, and for the same period of time in 1917-18 amounted to \$22,946.02. Because of the dirty boilers and the greatly inferior quality of coal delivered, a much larger quantity was consumed. The question of prevention of smoke from our boilers is being studied, as it is impossible for the city consistently to demand smoke abatement of manufacturing and other plants if its own institutions do not prevent it. The architects of the hospital erected a wonderful modern hospital building, but put up a building for housing the power plant many years behind the times. Coal has to be handled three times before it can be put in the furnaces, adding twenty-five cents a ton to the cost of the coal. Recommendations for remedying these defects, which can be carried out at a moderate cost and which will result in a considerable saving, annually, have lately been made.

The hospital is equipped with an excellent refrigerating system and ice manufacturing plant of one and one-half ton capacity daily which, unfortunately, has not been kept up to its fullest efficiency and is now being renovated at some cost. The hospital does not need a large amount of ice and other city institutions will be supplied from the City Hospital plant, under an exchange voucher system, with a distinct saving to the city.

The building is in daily need of repairs, some of them frequently urgent. Requisitions for the engineering or carpenter departments are made on special blanks. These are O. K'd by the super-

intendent and endorsed by the engineer, and a man to whom the job was assigned, in turn, signs the requisition stating when the work was completed and what material was used. This blank from which the repair cost is computed, is then returned to the superintendent.

In winter, sufficient steam must be maintained to heat the building and sterilizing plants, in addition to supplying the hot water for the building, power for the laundry, and power to operate the electric light plant and elevators.

III. INTERN STAFF

The proper maintenance of a full supply of competent interns with rotation of service, during these trying days, is most difficult and serious. Most full-blooded Americans have a natural desire to get into the fray as soon as they are qualified, but fortunately the Surgeons-General of the Army and Navy consider a man much better qualified for military service after he has had a year's internship in an acceptable hospital. Medical students of draft age are in the Medical Enlisted Reserve Corps, obtaining a release from the draft in order to finish their medical studies. On graduation the young doctor is commissioned in the Medical Reserve Corps and placed on detached duty during the period of his internship, reporting, every three months, to the surgeon general, by letter, to be accompanied by a statement from the superintendent as to his acceptability and efficiency. In case of some great emergency he is at the call of the surgeon general. The class of 1918, in most medical schools, will be much smaller than for a number of years, and the number of interns available will necessarily be inadequate for all the hospitals in the country.

This has been the case in the Louisville City Hospital and, with the approval of the Board of Safety, six senior students have been appointed as student interns. They live in the hospital and do the work of graduate interns, except the administration of anesthetics and the signing of death certificates. Before the end of the session each member of the senior class who could do so will have served a term as resident student intern. The seniors have acted as admission officers and ridden the ambulance, and the experience gained has been invaluable to them.

A rotation of service is essential to the broad education of the intern, and the assistance rendered here by a competent resident physician is invaluable to the superintendent. He is valuable in seeing that histories are written up and the work kept up on the wards; in answering emergency calls, in the absence of the intern and visiting staff; and in transferring patients and keep-

ing the house clear of chronic cases, where possible, so that their beds may be ready for acute cases.

IV. NURSING

This includes selection of the nursing personnel, maintenance of the proper morale, arrangement of curriculum, and distribution and rotation of service.

The nursing personnel is a vital part of the hospital and its work. Much depends upon the type of woman who applies for admission to the training school. The legal requirement in Kentucky of a one-year high-school education is a wise one. The judicious weeding out of the unfit in the probation class is highly essential.

There are too many training schools for nurses in hospitals which are, because of their size, inadequately equipped and not prepared to give a complete course of training. An affiliation must be made with a larger hospital to supply the deficiencies in the curriculum. General hospitals with charity patients only can well affiliate with hospitals caring for pay patients, in order to give their pupil nurses a broader viewpoint.

The Waverly Hills Tuberculosis Hospital affiliates with the City Hospital, giving their nurses one year's training in surgery, obstetrics, pediatrics, and contagious diseases. Because of the inadequate training at Waverly Hills and the difficulty of obtaining sufficient probationers in this training school, an arrangement has been perfected for the City Hospital Training School to take over the Waverly Hills Training School, sending fourteen City Hospital nurses to Waverly Hills for a period of four months for training in tuberculosis nursing. This will do away with the duplication of the lecture courses in each institution, insure the same standard of entrance requirement, and remove the spirit of caste when two separate institutions are represented in the training school of one hospital.

The plan adopted by the Cincinnati General Hospital has much in its favor. Their training school for nurses has been taken over by the University of Cincinnati, which offers the nursing course as one of its science courses, one or two years of academic work and three years nursing leading to the science degree. The close affiliation of the Medical Department of the University of Louisville with the hospital enables the curriculum of the training school to be taken care of, for the most part, by the medical faculty.

V. LABORATORY

Highly specialized and equipped laboratories and pathological department are most important.

The laboratories of a hospital are essential to

its proper conduct. Here must be made examinations in serology, bacteriology, clinical microscopy, and surgical and morbid pathology. Intimate association between the school and hospital in this department with an all-time chief, is the only satisfactory method of carrying out the details of this work.

The hospital is equipped with ward laboratories where the laboratory nurse, changed each six weeks, makes all routine admission urinalyses, supplemented by examinations by the intern, if the urine is pathologic. The students, in their capacity of ward clerks, do the subsequent urinalyses and blood counts in those cases assigned to them. The autopsy service at the City Hospital is not surpassed anywhere. It is largely what the interns make of it, as many autopsy permissions can be obtained if properly presented to relatives or friends. The members of the senior class, whose teaching activities are confined entirely to the hospital now, are required to witness ten autopsies and present a protocol of each as a part of their undergraduate record. Much could be written of the value of a well-equipped laboratory to the clinician, but this is superfluous here. The excellent record made in cases of epidemic cerebrospinal meningitis this winter, following prompt laboratory diagnosis, is but one evidence of the practical application of these facilities.

VI. LAUNDRY

The economical and efficient operation of the laundry department, with prompt delivery of the finished products, is a problem to be met. We found white goods being washed with blue ginghams with resultant staining of the white goods beyond possibility of bleaching. It was formerly the custom for the orderlies on each ward to call for and deliver, to their own and the female wards, the clothing and bedding which was marked and kept separate for each ward. This method of delivery kept the orderlies off their wards for long periods at a time, and a messenger boy has since been employed for the delivery of supplies from storerooms, drug rooms, and laundry. The method of separating clothes has been discontinued also, all wards requisitioning on the laundry for supplies. The operating room and the isolation and baby wards are kept separate from the general ward supplies.

VII. KITCHEN

The economical and tasteful preparation and service of food, to patients and to staff, are two distinct problems.

There has never been a regularly employed dietitian at the City Hospital. This department is one of the most necessary to the success of an

institution. Food values must be computed, bills of fare for patients, help, nurses, and doctors, must be carefully thought out and the preparation of food in the kitchen must be supervised. Most important is food conservation and waste. We found that formerly all garbage was incinerated on the wards; hence there was no idea of the food waste. Proper garbage containers were ordered and all food waste was collected from the wards. Much to our surprise, the first week showed a waste of 3,531 pounds, which was sold on contract for fattening hogs. Steps were taken at once, looking toward the cutting down of this waste. We had heard of the excellent system in use at the Base Hospital convalescent dining room at Camp Zachary Taylor,² and a visit was made there at the dinner hour. Captain Deenen, M. R. C., in charge of this dining room, addressed the men before they sat down and pointed out that every man was expected to eat all he wanted, but he was not to take any more food on his plate than he could eat. Not more than half a pint of waste was left on the plates of 275 men when the meal was finished. The commanding general was asked to detail Captain Deenen to the City Hospital to have him make the same talks to the patients and help in the hospital, which was done. The results have been most gratifying. The average weekly amount of garbage has been reduced to 2,340 pounds. The cooperation of nurses and maids with the department of dietetics is responsible for our success in meeting this problem of waste.

VIII. BAKERY.

By installing this department a better quality of bread is made, and pastries and other delicacies can be served, which is not possible if this department is not operated.

A bakery, with an old-style but efficient oven, was included in the general plan of the hospital, but was never used. Investigation showed that, while it might not prove economical to operate the bakery for making the bread consumed in the hospital alone, supplying the bread used at the other city institutions would make it profitable. Pending the arrival of the Ford truck ordered to deliver bread and ice to the other institutions, a cost account has been kept of the bakery, which shows the following:

Three hundred and nine pounds of bread made at the hospital at a cost of \$17.52 (the cost of 7 cents a pound paid for bread under contract would have been \$24.64) resulted in a saving of \$7.12 a day, and the hospital has had a much better grade of bread.

The employment of a baker enables the hospital to have pastries and other delicacies, which otherwise would be impossible. The bread made in our own bakery is more nutritious than the former supply. We make a pound-and-a-half loaf—six loaves to the pan. This minimizes the amount of crust and this size loaf cuts more economically.

IX. HOUSEKEEPING

The upkeep and constant cleaning of the hospital is one of the most vital to the successful operation of the plant. The housekeeper must see to the maids and janitors, and to the washing and cleaning of windows, wards, and halls. The fact that there are 5,477 window panes in the hospital emphasizes the difficulty of this detail. She must also keep up the supplies for all departments, save the engineering and drug-store. Only eternal vigilance can produce cleanliness in this climate. The scarcity of labor has been a very serious handicap in this department also.

X. OUT-PATIENT DEPARTMENT

The maintenance of a free dispensary easy of access to the sick poor is essential.

The out-patient department of a large general hospital is a necessary adjunct to it. The City Hospital cares for a walking clinic of from 200 to 225 patients daily. It is true there are many cases which impose on the generosity of the city in being cared for when well able, financially, to pay for their medical advice, but our social service department will shortly be able to do much toward solving the problem of eliminating these impostors. Much could be said of the excellent work being done by this department of the hospital which has been lately established. Social diagnoses are made of all bed cases, and homes are investigated before patients are discharged, thus obviating neglect and the possibility of the patients being readmitted to the hospital. The enlarged venereal clinic,³ which is being conducted with the collaboration and active assistance of the U. S. Public Health Service, is worthy of special mention, as it is bringing expert advice and treatment to the infected people of the community who otherwise would generally receive no medical attention.

An average of eighty injections with arsenobenzol are given each week, the drug being furnished by the Public Health Service. The hospital maintains a supply which it dispenses at cost to those who can afford to pay for the medicine but who cannot pay for its administration.

The Public Health Service pays the salary of

² Described in THE MODERN HOSPITAL, July 1918, p. 51.

³ Described by Dr. Stuart Graves in THE MODERN HOSPITAL, May, 1918, p. 378.

two all-time assistants in the out-patient venereal clinic, one of whom also acts as admission officer for the hospital. They also pay the chief of the laboratory service and an assistant for the necessary serological work done for the venereal clinic. Salvarsan is administered Tuesdays and Fridays in the out-patient department.

The drug store of the hospital is a depository for the State Board of Health biological products produced by Squibb, and a complete stock is kept on consignment, being paid for as used. The antirabic vaccine will shortly be installed through special arrangements. Those who can pay, can obtain it at cost. An average of 180 prescriptions are filled here each day, in addition to which prescriptions for the District Nurses' Association and the Tuberculosis Hospital are filled.

X. VISITING STAFF

It is needless to state that a hard-working, conscientious, and deeply interested visiting staff is essential to a successful hospital. There must be hearty cooperation in all departments, and the freest consultations between department heads.

There may have been many changes in the staff owing to the demands of the Army Medical Corps,

but the gaps have been filled in and the sick are getting every attention.

There may have been many changes in the staff worked out, but these will be taken up in due course.

We have found much help in weekly or bi-monthly round tables, at which the heads of all departments are present. Here the problems of one department which may involve another are discussed and a mutual helpfulness engendered. Instead of cross-purposes and criticisms, there is more of a spirit of pull together which is for the betterment of the entire service.

The following, which we hope will add to the efficiency and usefulness of the hospital, may be mentioned as having been introduced; a social service department; a dietitian; the operation of the bakery; two all-time men in the out-patient department to look after the venereal clinic and between hour patients; serving patients' meals one hour later than formerly; student interns to fill in the intern service; a new ambulance; serving bread and ice to other city institutions; and a start at the painting of the entire interior of the building.

HOSPITAL ACCOUNTING

Books That the Superintendent Should Keep — Journal, Charge Register, Pay Roll, Pay Patients' Ledger, Cash Income — Method of Keeping These Books

By CHARLES A. PORTER AND HERBERT K. CARTER, OF THE STAFF OF THE MODERN HOSPITAL

(Continued from August issue, p. 107)

BOOKS AND ACCOUNTS OF THE SUPERINTENDENT

The Superintendent of the larger institutions keeps all of the books that deal with the operation of the hospital, and makes a report to the Treasurer, who keeps the corporation books and controlling accounts.

The books that the Superintendent should keep are:

1. Journal.
2. Charge Register.
3. Pay Roll.
4. Pay Patients' Ledger.
5. Cash Income.

6. Cash Expenditures.

7. Expense Analysis.

8. General Ledger.

9. Trial Balance.

The Journal is one of the original books of entry, and takes care of all items that cannot be entered directly into the Cash Book or Charge Register, such as uncollectable accounts receivable charged off during the month, overpayments by patients transferred to miscellaneous hospital earnings, losses and depreciation of supplies, etc.

JOURNAL ENTRIES

It is necessary for the ordinary hospital to keep but six different classes of entries in this book, examples of which are given below:

1

Superintendent's account with Treasurer.....	Dr. \$.....	
Accounts receivable.....	Cr.	\$.....
For uncollectible accounts receivable charged off during the month.		

2

Overpayments by patients.....	Dr. \$.....	
Accounts receivable.....	Cr. \$.....	
For overpayments by patients for services unrendered and not liable to be refunded to patients, and therefore transferred to miscellaneous hospital earnings by authority of.		

3

Supplies, inventory.....	Dr. \$.....	
Superintendent's account with Treasurer.....	Cr. \$.....	
Inventory at end of period to offset amount charged off for supplies during period.		
This entry will not have to be made where a monthly charge to departments for supplies is kept, except to balance account at end of fiscal year.		

4

Superintendent's account with Treasurer.....	Dr. \$.....	
Supplies.....	Cr. \$.....	
Charge for depreciation and other losses.		

5

Superintendent's account with Treasurer.....	Dr. \$.....	
Unclaimed wages.....	Cr. \$.....	
For unclaimed wages transferred to miscellaneous hospital earnings.		

6

Discounts.....	Dr. \$.....	
Superintendent's account with Treasurer.....	Cr. \$.....	
For the transfer of discounts to the Superintendent's account with the Treasurer in case a profit and loss account is not kept in the Ledger.		

When the Journal entries 1 and 3 are made, notations should be made on the Pay Patients' Ledger Cards, showing the date of such transfer.

Where it is necessary for the Superintendent of a hospital to open a set of books by the double entry system, entries must be made in the Journal in order to open the necessary Ledger accounts

to which entries may be posted and referenced. Accounts which it will be necessary to open are: Pay Patients' Bills Receivable, Advance Payments by Patients, Overpayments by Patients, Bills Payable, Equipment, and Superintendent's Account with Treasurer. He may open these accounts as shown by the following examples:

1

Superintendent's cash account.....	Dr. \$.....	
Superintendent's account with Treasurer.....	Cr. \$.....	
For cash on hand the last day of the month, not including overpayments or advance payments by patients.		

2

Superintendent's cash account.....	Dr. \$.....	
Advance payments by patients.....	Cr. \$.....	
Account advance Payments on hand the last day of the month.		

3

Superintendent's cash account.....	Dr. \$.....	
Overpayments by patients.....	Cr. \$.....	
Account overpayments by patients.		

4

Bills receivable Charge Register.....	Dr. \$.....	
Superintendent's account with Treasurer.....	Cr. \$.....	

5

Supplies account Charge Register.....	Dr. \$.....	
Superintendent's account with Treasurer.....	Cr. \$.....	

6

Superintendent's account with Treasurer.....	Dr. \$.....	
Bills payable account.....	Cr. \$.....	

SUPERINTENDENT'S CASH ACCOUNTS

The use of three books by the Superintendent for the handling of all cash transactions is recom-

mended. These are: General Cash Book, Pay Patients' Cash and Receipt Book, and Combination Cash and Check Book.

The daily totals of the Dispensary and Pay

Patients' books, payments to the Superintendent by the Treasurer, and sales and miscellaneous receipts are entered in the General Cash Book and a bank deposit slip made out to correspond therewith.

The Pay Patients' Cash and Receipt Book (Form 20) gives an itemized statement of payments by patients. In cases where someone other than the patient makes payment, this fact is recorded. The individual Pay Patients' Ledger Cards (Form 21) are posted direct from this book. The same form of receipt may also be used in the dispensary and emergency wards. The use of this form saves the posting of such items to the Cash Book, and consequently saves time and reduces the chances of error.

The Combination Cash and Check Book (Form 18) and its companion book, the Charge Register (Form 13), give a complete record of all cash expenditures, including copies of the checks and distribution of the expenditures.

The General Cash Book (Form 17) is arranged to show the totals of the principal daily receipts and expenditures and detailed entries of cash transfers between the Superintendent and the Treasurer, and other miscellaneous items. (Forms 17, 18, 19, 20, and 21 are shown in later instalments.)

On the debit side of this Cash Book columns are headed hospital earnings and miscellaneous. Hospital earnings are subdivided into ward patients, private room patients, dispensary, emergency ward, and other receipts. More columns may be used if desired, but these will be enough to enable the average institution to make an easy recapitulation at the end of the month.

In hospitals where the volume of business is so great as to make further reductions necessary, headings for each of the other main sources of hospital earnings may also be used, such as x-ray service, special nurses, laboratory fees, telephone, and sundries.

The credit side of the Cash Book has columns for dates, payees, discounts, refunds to patients, bills payable, and miscellaneous. Cash discounts should be entered in this book, although, strictly speaking, they are not cash items, but are reductions of payments.

Transfers of cash between the Superintendent and the Treasurer are entered in the miscellaneous columns, debit or credit, as the case may be, and posted direct to the Superintendent's account with the Treasurer.

At the end of each month a recapitulation of all cash receipts should be made on the debit side of the Cash Book in the following form:

January 1. Cash on hand	\$.....
Hospital earnings:	
Private room patients.....	\$.....
Ward pay patients.....	.....
Dispensary.....	.....
Emergency ward.....	.....
Ambulance fees.....	.....
Special Nurses.....	.....
Guests' fees.....	.....
Operating room fees.....	.....
X-ray fees.....	.....
Laboratory fees.....	.....
Hydrotherapeutic fees.....	.....
Sales of refuse.....	.....
Miscellaneous.....	.....
Total hospital earnings.....	\$.....
Received from Treasurer.....	.....
Etc.....	.....
Etc.....	.....
Etc.....	.....
Total receipts.....	\$.....

A recapitulation of cash expenditures should be made on the credit side of the Cash Book in the following manner:

January 1.	\$.....
Accounts payable.....	\$.....
Refunds to patients.....	\$.....
Cash remitted to Treasurer.....	\$.....
Total payments.....	\$.....

[Cash on Hand:

Advance payments by patients.....	\$.....	
Overpayments by patients.....	\$.....	
General cash.....	\$.....	\$.....
Total.....		\$.....

The totals of the two recapitulations should agree.

In hospitals where the receipts are remitted to the Treasurer it is not customary to remit advance payments by patients and overpayments by patients, as they represent funds which have not been earned by the hospital and are simply held in trust by it. These two items are shown in the Cash Balance in the Cash Book in order to make it unnecessary to keep a cash account in the Superintendent's Ledger.

POSTING

All cash items should be totaled and posted to their respective Ledger accounts as follows:

Cash received during the month on account of hospital earnings should be credited direct to accounts receivable.

Cash received from the Treasurer should be posted direct to the credit side of the Superintendent's account with the Treasurer.

Cash disbursements on account of accounts payable should be posted direct to the accounts payable account.

Cash remitted to the Treasurer should be posted direct to the Superintendent's account with the Treasurer.

Discounts as shown by the discount column are posted direct to accounts payable and transferred to the discount account through the Journal. These do not appear in the recapitulations on the Cash Book pages because they are not cash items, but are savings made by the timely payments of bills rendered to the hospital.

Cash refunded to patients during the month on account of overpayments are debited direct to overpayments by patients' account.

Reference should be made in the folio column of the Cash Book to the pages in the General Ledger to which the various postings are made.

SUPERINTENDENT'S PETTY CASH FUNDS

It is necessary for the Superintendent of a hospital to have a petty cash fund from which to pay small current items, such as messengers, postage, time checks, express, and miscellaneous items.

By studying past conditions, the accountant can estimate the amount of money needed in this petty cash fund. At the end of each month, and at times during the month if necessary, checks are made out to bring this fund up to the amount

called for on the general books. The proper handling of this fund is one of the most important parts of a complete accounting system.

When making petty cash payments, Form 11 should be used and the signature of the payee secured. This petty cash voucher should show the item for which the money is spent and the account

PETTY CASH VOUCHER		No. 49
Received from		Dollars
from THE MODERN HOSPITAL		
Payment in full of following		
Date	Signed	
FOR	DEPARTMENT	Amount
Approved		Sub't.

Form 11. Petty Cash Voucher. Actual size, 5 by 3 inches.

to which it is to be charged. These vouchers are placed in an envelope (Form 12) at the end of the month, which shows the voucher numbers, the date, Invoice Jacket covering these and the distribution of the expenditures. The distribution to departments or accounts is shown, and the total on the envelope plus the cash remaining on hand must equal the amount of the fund. A check is drawn to cover the expenditures as shown by the Invoice Jacket, and these transactions are complete.

VOUCHER NO.	
PETTY CASH VOUCHERS	
Nos. TO INCLUSIVE	
DATE 191.....	
DISTRIBUTION	AMOUNT
CORPORATION	
POSTAGE	
MISC	
DEPARTMENTS	
TOTAL	
TIME CHECKS DEPT	
REFUNDS TO PATIENTS	
TOTAL	

Form 12. Petty Cash Voucher Envelope. Actual size, 3½ by 5½ inches.

CHARGE REGISTER

The foundation of cost accounting for hospitals is the Charge Register (Form 13). It replaces the Bills Payable Ledger, and gives a complete record of all transactions for which money has been or is to be expended by the Superintendent for bills payable. As soon as bills are received, Invoice Jackets should be made out and entries made in this book.

Column headings, arranged to correspond with the classification of expenses as determined on

As explained in the introduction to this text, it is impossible to show a form of Charge Register that will exactly suit the needs of every hospital.

At the end of each month the columns of the Charge Register are footed, and it is a simple matter to make the necessary recapitulations in order to show the totals of each division of expense entered upon the Expense Analysis (Form 22.

Form 13. Charge Register; above, the left-hand page; below, right-hand page, 19½ by 15 inches. Bound book, with binding margin to be added at left of right-hand page and right of left-hand page.

General Ledger accounts to which sundries are shown in a later instalment) or to their proper General Ledger account. A folio column is given, so that these may be properly referenced.

Moving Pictures Displayed on Camp Hospital Ceilings

The problem of how to amuse the wounded soldiers who are unable to sit up has been solved in a simple manner by the Y. M. C. A. at the base hospitals in the camps. Portable motion-picture machines are so stationed that the projections appear on the ceiling, and all the patient lying on his back need do is to look up.

In connection with the recreational and entertainment work for the wounded and convalescent soldiers in the cantonments the Y. M. C. A. War Work Council has just given to the Lythic Construction Co., of New York City, the contract for the erection of a large hut at Camp Upton. It will be 80 by 53 feet, with a high gable roof and a large chimney at one end, giving it the appearance of an immense farm house of the typically New England home-like sort—the kind suggestive of home comforts and of “the pies mother used to make.” The building will be ready for use within six weeks.

One of the features of a novel nature will be the so-called "quiet room," where anyone who desires to be alone can go. Another noteworthy matter is that there will be a grand veranda running the entire length of the building and overlooking the athletic grounds.

Two lady visitors were walking down the regimental street. One said: "I like everything about this camp. The tents and buildings and streets are all kept so clean."

The other said (as they passed an incinerator), "Yes, but I don't think they make their coffee in a very sanitary way."—Trench and Camp.

LIFE-SAVING SURGICAL DRESSING SQUADS IN FRANCE

**St. Didier and Its Output of Surgical Dressings—Human Interest in Surgical Supplies—
Manufacture of Dressings Saving Lives of Workers as Well as Wounded**

BY CHARLOTTE H. CRAWFORD, OF THE AMERICAN RED CROSS

HE HAD been hanging for nineteen months slung in a kind of hammock. There were various pulleys and appliances, but the main thing which kept him alive all that time was an ingenious dressing which could be adjusted to his back without disturbing him. That means something to a man whose spinal cord feels like one long toothache. For nineteen months, this merciful arrangement had made it possible to dress his terrible wound, and at last he was beginning to get better. The day came when the pulleys were shifted to bring him to a sitting posture. For the first time, he looked about the big hospital room. Over the door was festooned the tricolor. He raised his hand to salute, and cried out: "*Vive la France!*" That was the spirit which an up-to-date surgical dressing had saved to France and the world.

Somehow, you think there is rather less of human interest about a surgical dressing than about a muffler, say, or a warm shirt or good woolen socks. These things take on something personal, something that reminds the wearer how close he is to the heart of the folks at home. A surgical dressing is put on one day and burnt up the next. While it is being put on, the soldier is too busy with his pain to think of the hands which folded it or the devotion which toils day in and day out to turn it out in quantity.

Rather less of human interest about them, isn't there? And deadly work to make them, shouldn't you think? Wait till you have had a look at St. Didier!

To St. Didier one used to go to rent a tennis-court. (The French seem to fancy the tennis-court as historic background.) Now it lends its



Fig. 1. A Red Cross surgical dressing workstation on this side.



Fig. 2. An American-made surgical dressing being applied "over there"

ample spaces to the American Red Cross for the storage of great cases of gauze and surgical supplies, and its wide light rooms make admirable workrooms.

Since a mere trifle of several million dressings are sent over from the United States every month, St. Didier is confining itself to the manufacture of what is known as "front parcels." These are in three sizes, for large wounds, small wounds, and middle-sized wounds. They go to the advanced emergency stations and contain each a complete dressing for one wound. They are wrapped in sterile bags before being put in paper and paraffined. By pulling on a string, the surgeon has the whole contents open ready to his hand. Some of the women at work in St. Didier turn out one hundred and thirty of these in a day, the average number per worker being seventy. As there are three hundred and fifty paid workers at St. Didier, not counting volunteers, you may form some estimate of the daily output of dressings turned out in this great workshop.

Looking over these busy rooms, the bandage-machine rolling the material in great rolls, the cutting-machine measuring off the rolls into different sized bandages, and the nimble human machines, folding, preparing, and packing the output, you feel inclined to liken it to a great life-saving station; for before your mind's eye there rises up the vision of another room—an ambulance dressing-room near the front.

Along the walls are tables, spread with sterile towels and neatly piled with all kinds of dressings. The orderlies bring in a badly wounded man on a stretcher and lift him to the operating table. Off comes the old dressing, blood-stained and foul with pus. It is tossed into a pail to be burnt up.

The surgeon reaches out a pair of interrogative forceps, and the nurse deftly jabs hers into a pile of dressings, and hooks the very thing he needs, and there is no break in the chain until the *blessé* is lifted back on the stretcher, with his wound cleaned, dressed and protected from infection by a fresh dressing. And sometimes, when it is a busy day, with no time for cleaning up between *blessés*, the floor gets slippery under the feet of surgeons and nurses, and the cast-off tampons and bits of gauze lie about, red with the costly dew that is keeping the trees of Liberty alive for all the world. So even these little cast-off, disregarded scraps of gauze have a part in the great fight against despotism, and blush with a decoration before they are swept away!

Not much human interest about surgical dressings, did you say?

The Red Cross is now employing about five hundred women workers at its three big workshops in Paris. Incidentally, they are doing a life-saving work right there. Most of these women are refugees, only too glad to work for something less than a dollar a day. At the present moment, that is hardly a living wage in Paris, and the Red Cross is about to open a canteen where these women workers can get at least one good free meal each day.

But, you say, with several million dressings a month from the United States, and three workshops going full blast in Paris, will the Red Cross not be overstocked with surgical supplies? Up to the present, there have never been too many. What the future holds, we cannot say. But one thing, we are resolved, it shall not hold—the loss of precious life through lack of life-saving devices in the shape of up-to-date surgical dressings.

A NEW EXPERIMENT IN TEAM-WORK FOR THE PUBLIC HEALTH

The Cincinnati Public Health Council—An Interesting and Successful Plan for Coordinating Community Effort—Form of Organization and Methods of Work

BY COURTENAY DINWIDDIE, EXECUTIVE NATIONAL SOCIAL UNIT ORGANIZATION, CINCINNATI

THERE is nothing on which it is easier to secure a general and enthusiastic agreement than the need of common planning and team-work for the public health. It is easier to agree upon generalizations. But, sometimes, when we come to particulars, we find that the other man's idea of cooperation is to let us do the work, or to have us do just what he wants; or perhaps he has similar opinions about our own ideas. It is when we translate our attractive phrases and our general ideas into concrete forms of organization or methods of planning and working together that we can really tell what we mean and how nearly we are in agreement.

These are times in which it is of vital importance for us to conduct a searching inquiry into the real value of our methods of cooperation, of elimination of friction and waste effort, and of conservation of energy. This is particularly applicable in the public health field, as every new fact disclosed by a study of conditions in the warring countries reemphasizes the urgent necessity of taking time by the forelock in planning and carrying out preventive health work as a war measure. England's splendid success in reducing infant mortality in the face of war-time conditions is a positive illustration of the import-

ance of preventive measures. Where public health measures have not been forehanded but rather have been adopted after health problems have become acute, the increases in tuberculosis and other diseases paint an appropriately somber negative background.

There have been more examples of efforts to bring about coordination and team-work in the



Fig. 2. This West End tenement, with a record of three cases of tuberculosis in one year, is a type of the conditions which Cincinnati has set out to abolish.

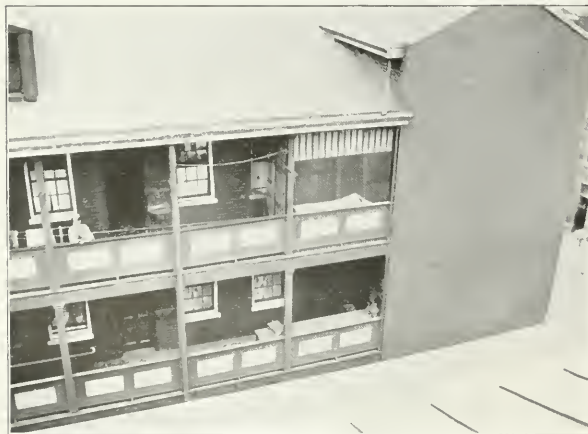


Fig. 1. This sleeping porch was screened and fitted up by the Anti-Tuberculosis League, the organization which was the forerunner of the Cincinnati Public Health Council. In addition to its efforts for city-wide improvement of housing and living conditions, the league is continually helping in the individual homes. It maintains a nurse and a visiting housekeeper, and in every way endeavors to help families to raise the sanitary and economic standards so as to eliminate disease-producing conditions.

general field of social service than there have been in purely health activities. In the main, the general principles underlying forms of organization or methods of work in the two fields are much the same, and successes or failures in the one may be taken as typical of the other. We have a number of examples of such efforts in public health leagues, community welfare associations, councils of social agencies, and other similar organizations.

Usually, in the formative period of such organizations, there is a laudable effort to secure democratic representation from the various agencies, and an opportunity for the different interests which are coordinated to continue to express their views and carry out their purposes. Unfortunately, however, there often arise examples of working at cross-purposes and instances of constituent agencies feeling that there is an attempt to dominate or eliminate them

without open and friendly discussion of points at issue.

Probably the chief cause of such conditions has been the lack of a definite plan of organization from the bottom up in social service. Usually the central organization, whether existing before the federation or formed for the purpose of federation, comes to be considered as a separate organization apart from its constituents. The board of directors, however its election is provided for, is apt to be a self-perpetuating body in which some of the other agencies do not have a

There are eleven divisional councils, on tuberculosis, hospitals, mental hygiene, social hygiene, housing, recreation, medical relief, waste, nursing, industrial health, and child hygiene. Membership in each divisional council is open to any public or private agency or institution, or civic, business or labor body, which has a legitimate interest in the field of the council's work. Each member agency is entitled to one representative on each divisional council.

These divisional councils are the initiators of programs, plans, and methods of work in their own particular fields. All the councils have met several times and agreed upon programs for the solution of their particular problems.

The spirit in these meetings has been excellent. It has developed that agencies working side by side have not known many things about one another's work and have not fully understood each other's objects and methods. These divisional councils have furnished excellent forums for full, frank, and friendly discussion of these problems as a basis for mutual understanding. As a result, the programs drawn up have represented, not a superficial, but a real unanimity of opinion. In a particular field one or two agencies may stand out as the leaders because of their position and objects. But, instead of "going it alone" or having a casual cooperation, these agencies secure advice and suggestions from all the others in the same divisional council. As a result, the others not only give heartier and more understanding support, but can aid in carrying out many parts of the program through helpful adjustments in their own fields and direct service.

real voice in planning policies and methods of work. This might be taken as a condemnation of federation in social service or public health work, but it is by no means so intended. Federation and coordination are timely and necessary, and without them we shall not improve our present methods of work to any very considerable extent.

I believe that the real causes of the difficulties that are met in efforts for better organization are to be found in the lack of provision for common planning, frequent and intimate discussions of policies, and definite cooperation in actual service. The form of organization and methods of work of the Cincinnati Public Health Council are an expression of the thought of some of those in Cincinnati who have desired to bring about a better form of team-work for the public health. In brief, its organization is on the following plan:



Fig. 3. The Bamford Hills Camp, maintained by the Cincinnati Anti-Tuberculosis League for anemic children, has been one of the league's most successful activities. One of the mothers "never seen anybody that was as skinny and poor as these girls were get so far in so short a time in my life."



Fig. 4. Two crops produced in the camp are healthy children and healthy vegetables. The children have taken great interest in the gardening, and the fresh vegetables produced in the camp garden have helped to reduce the expense of food materially. In 1915, for instance, the maintenance cost per child per day was 35.5 cents, and the average cost of food per meal was 6.96 cents.



Fig. 5. The picnic lunch is a special camp privilege. Although each child makes up his own bed and takes turns in performing other light tasks about the dormitory and kitchen, most of the days are spent in wholesome recreation.

In fact, it was the demonstration of these principles in the Municipal Tuberculosis Committee, organized by the Anti-Tuberculosis League,¹ which led to the organization of the Public Health Council. Meetings from time to time have given opportunities for revision of plans and policies and for working out methods of carrying into effect programs adopted.

The coordinating force among these divisional councils is the public health council as a whole,



Fig. 6. A city-wide campaign against the pernicious practice of spitting in public places was inaugurated in April, 1916. A corps of 700 workers, including 400 Boy Scouts, on April 17, painted on the main street corners and at frequent intervals on many sidewalks the sign, "Don't Spit on Sidewalks." Through the cooperation of the police this campaign was carried out quietly and thoroughly and proved most effective in attracting attention. It was followed by a newspaper campaign and arrest of spitters.

¹ For an account of the work of the Cincinnati Anti-Tuberculosis League, see "Cincinnati's Successful Antituberculosis Campaign," by Courtenay Dinwiddie (THE MODERN HOSPITAL, December, 1916, p. 400).

to which every member agency is entitled to send two delegates, an executive of the agency and another representative, usually a member of the board of directors, except in the case of public departments and institutions. The reports and programs of the divisional councils come in to the public health council for coordination and approval. The chairmen of the divisional councils, together with the officers of the public health council, constitute a coordinating committee, which considers proposed programs and amendments and then submits its recommendations to the public health council as a whole. In case of need for immediate action the coordinating committee is authorized to act in the interim between meetings of the entire council. The discussion of the recommendations of the divisional councils by this coordinating committee has proven another valuable means of securing better understanding and closer cooperation.

A still further step of great importance has been taken in Cincinnati in an agreement between the public health council and the council of social agencies, by which the former has become the autonomous public health division of the latter. This is a long step forward toward real organization of community effort. It is also a tribute to the democracy of the Cincinnati Council of Social Agencies and to the cooperative spirit of both organizations.

Having laid this new foundation under public health work of the city, our next move should be to see to it that the foundation rests solidly upon the people of the city as a whole. Only with such support will public health work reach its ultimate goal.

The work of the council is now going forward encouragingly under a full-time executive, Mr. Arthur H. Burnet, for five years the director of the social service division of the health department of Toronto.

Work thou for pleasure; paint, or sing, or carve
The thing thou lovest, though the body starve.
Who works for glory, misses off the goal,
Who works for money, coins his very soul;
Work thou for work's sake, and it well may be
That these things shall be added unto thee.

—Kenyon Cox.

Let us see to it that nothing good in us goes unexpressed; for every right impulse given effect we gain a thousandfold.—Stephen Berrien Stanton, "The Hidden Happiness."

When one door closes another always opens, but we usually look so long, so intently and so sorrowfully upon the closed door that we do not see the one that has opened.—Jean Paul Richter.

LITTLE JOURNEYS TO PLACES AND PEOPLE WORTH KNOWING

The Fourth Little Journey—To Grant Hospital, Columbus, Ohio—A Private Hospital, Free from Commercialism, Giving Care to People of Moderate Means

BY MARGARET J. ROBINSON, R. N., FIELD EDITOR OF THE MODERN HOSPITAL, CHICAGO

I SAT waiting for a while in a little reception room at the right of the entrance hall in Grant Hospital, and had plenty of time to count the stars in the service flag, seventy of them, and the sign on the wall reading, "Turkish Bath, Barber Shop and Cigar Stand in the Basement." This looked good. What a time-saver it must be not to have to send a nurse or orderly or someone else around the corner every time that Tom, Dick or

There are 250 beds in the hospital buildings. The training school has 115 student nurses enrolled and to meet the national need, is enrolling more as fast as accommodations can be provided for them. The hospital employs a force of competent office clerks, bookkeepers, interns, laboratory assistants, dietitians, supervisors, and domestic attendants.

Ten percent of all patients cared for in the hos-



Fig. 1. The walks and trees of Grant Hospital blend with the Library Park opposite

Harry wants a package of cigarettes or of chocolate or the evening paper—and what a blessing it must be to have a barber handy when you want him for a patient!

When Miss Jamieson, the superintendent, was free to attend to stray visitors, I followed her about for an hour or more, getting acquainted with the physical properties of Grant Hospital and trying to learn something of the spirit of its work.

In so far as we know, Grant Hospital is the largest privately owned hospital in the United States. It was originally started by a stock company of doctors and other individuals and was considered as an investment, but at the present time it is owned by a company of physicians, organized by Dr. J. F. Baldwin on the "not for profit" basis provided for by the laws of Ohio, and is managed just as any general hospital would be managed. The surplus funds, when there are any, are used to pay indebtedness, or are returned to the hospital assets to provide for the growth of the work done.

hospital receive free treatment. No deserving patient is ever refused admission. Officers and men of the aviation camps nearby are cared for at the rate paid by the government, which is less than half their cost of maintenance in these days of inflated prices for everything we use in hospitals. Sick children who are taken care of in the fresh-air camp during the summer and who are too ill to be returned to their homes are treated free in the children's ward during the winter months.

Perhaps the thing of greatest importance in Grant Hospital is that the largest part of all service given to the sick is to people of moderate means for moderate rates. There are many rooms for \$18 a week. Mothers and babies get care in wards for \$18 a week and in private rooms for \$3 a day. There are never more than four beds in a ward. It is a rule of the house that each patient must have the ventilation from one window for his own.

It is no wonder that Grant Hospital is nearly always full to capacity. The wonder is that the institution can accomplish what it does and still re-

main on a self-supporting basis, as it actually does.

The hospital is an open-door institution, but open only in a restricted sense. No physician or surgeon may use the hospital for his patients un-



Fig. 2. One of the pleasant two-room suites with bath.

less he has been passed upon by an efficiency committee of the staff, which must satisfy itself as to his ability before he is permitted to bring his patients for treatment. When there is any doubt, if the applicant is a surgeon, the chief surgeon of the hospital and a committee of his associates witness the early operations personally.

There are twelve pupil nurses and two supervising nurses on duty in the operating wing of the building. The records show an average of 350 cases per month. The surgical suite is equipped



with an emergency laboratory, which has a freezing microtome. The radiographic laboratory and cystoscopic room in this suite adjoin, in order that rapid service may be given and skiagraphs made for patients needing an urethral diagnosis.

A desk is provided in what is known as 'the doctors' room, where an immediate record of operations may be made by the doctors themselves following their operative work. Nose-and-throat work is done in a separate department of its own,

which has special operating rooms and private rooms and ward and recovery rooms. This is entirely away from the general surgical service and away from patients in all other departments.

All nurses on duty in operating and obstetrical delivery rooms are served with sandwiches and hot or cold drinks in the middle for the forenoon and afternoon. All operations are posted on the operating board—"boarded," to use the technical expression—directly with the operating room supervisors.

The housekeeping department of the hospital is decidedly interesting, but, as Miss Jamieson tells all about it in a paper which was read at the Ohio Hospital Association meeting,¹ I shall not persist on that field here. Her three neat little maids, all sisters, who follow each other through the rooms



Fig. 4. The systematic and ever-ready maternity room.

after the patients leave them, show a splendid way of working out this problem of getting rooms into use again with the least amount of red tape and time and labor.

Officers, supervisors, nurses, and clerical employees at Grant Hospital all eat in the cafeteria. The service is economical and swift and the food good. I do not report this from print or hearsay, because I was a dinner guest myself the day I visited the hospital. I stood in line behind the superintendent, picked up a big tray, and helped myself to a knife and fork and spoon and napkin and glass of water. The girl behind the counter dished out a good hot dinner from the steamers all on one plate. Then I marched along behind Miss Jamieson to the supervisors' dining room, where we all sat down to talk hospital shop talk in peace, without waiting for further service.

After dinner we went back to the main offices. The hospital keeps a very complete card-filing

¹Published in THE MODERN HOSPITAL, July, 1918, p. 15.

system and has a sufficient force of people to keep it constantly checked and up to date. One woman clerk in the office is held responsible for admitting patients and is left free of other work so that she has time to perform this duty courteously and intelligently.

A stenographer in each office makes four copies of the patient's admittance history for each one that enters. The first copy remains on the room clerk's desk. The second copy goes to the switch-board, where there are three eight-hour-shift operators; the third goes to the superintendent of

entered the reception room I noticed two framed quotations on the walls, one placed just where the eyes of each patient who enters the room can not help but see it, and the other under the eyes of each one who leaves the offices. They will express



Fig. 6. The nurses in line. Serving the hot dinner from the steam tables.

to you, better than I can, the motives that govern the daily life of this private hospital and the people who own and supervise it:

"Let the surgeon be chaste, pitiful, merciful; not covetous or extortionate, but rather let him take his wages in moderation according to his work and the wealth of



Fig. 7. A cozy room where the nurses do the charting.

his patient and the severity of the disease and his own worth."

—Guy de Chauliac, 16th Century.

"If your fee is first with you and your work second, then fee is your master and the lord of all fee, who is the devil; but if your work is first with you and your fee second, then work is your master and the Lord of all work, who is God."

—John Ruskin.

A friend writes from France: "The American hospitals are beyond anyone's comprehension here, so hygienic and so comfortable. One has 20,000 beds; they have their own railways, which bring the patients right in, and their own post. Talence Hospital is now magnificent."—British Journal of Nursing.



Fig. 5. All ready for the hot and cold drinks for the nurses' dinner.

nurses, and the fourth is filed on the patient's daily bedside chart.

The patient's room list is a large book with black pages. It is made so that the slips of cardboard, on which are written the patient's name, may be slipped in and out of grooves. On the left of the page, hand-printed in white photographic ink, are the numbers of the rooms or ward beds. On the right of the names are the rates for each room or bed. The slips used are of different colors. Red signifies that the patient is going home, yellow that the room is reserved, green that the room is clean and ready for a new patient. It needs only a glance from a room clerk or switch-board operator to give accurate information concerning the rooms to be rented or of the movements of patients who are going in and out of the building.

Miss Jamieson took me over to Dr. Baldwin's offices, which are in a residence next door to the hospital, to see his system of case-record keeping, which is very interesting and complete. As we

FROM OUR FIELD EDITORS' NOTEBOOKS

Some Beautiful Architectural Features of an Ohio Mental Hospital—Another Progressive Sisterhood Hospital—A Successful Rural Community Hospital in Iowa—Good Work Done by the Children's Hospital, Columbus

Dayton State Hospital (Mental), Dayton, Ohio

Driving through the lodge gates, which are framed on each side by flower-covered pergolas, one gets a full front view of the hospital and the rounded colonnade of white pillars around the entrance porch. The porch and pillars were made by patients of the hospital under the supervision of the superintendent, who designed it.

This institution has beautiful lawns and gardens and

every day. It was thought at first that the patients would destroy them, but this never happens. The patients themselves care for the flowers as long as they will last.

Some of the patients at the Dayton State Hospital have been there as long as thirty-five years and among the last admitted are three young soldiers from the cantonments—men whose type of mentality was uncertain and could not stand the strain of war.

Mount Carmel Hospital, Columbus, Ohio

Mount Carmel Hospital is administered by the Sisters of the Holy Cross, whose mother house is at Notre Dame, Ind. It has a bed capacity of 175. All the supervising sisters of the training school are registered nurses of the state of Ohio, and there are eighty pupil nurses in training.

The hospital is well built and beautifully sanitary. The halls have very little hospital atmosphere and no hospital odors. Growing palms, color, and sunshine are everywhere.

In the diet kitchens the shelves are lined with attractive trays, set with china that looks more like home than hospital. The best private rooms are provided with Minton and Colport and Limoges.

On one of the upper floors completely equipped scientific laboratories are being constructed, and near the operating service is a large case-record room. The operating rooms have balconies where visiting medical men and relatives may witness operations without getting into mischief. In the obstetrical wing is what the nurses call the fathers' room—a room where the husbands of patients

in this department may rest and wait for the stork's arrival. The pleasant-faced, capable sister in charge of the operating and obstetrical rooms has been in that service for ten years. She must be as capable as the surgeons by this time.

A cozy sunlit parlor on the top floor is used as a nurses' recreation room. THE MODERN HOSPITAL was on the table



Fig. 1. A view of Dayton State Hospital (Mental) through one of the flower-covered pergolas at the lodge gates.

farm land. The day I saw the hospital most of the wards were empty, and groups of patients were everywhere outdoors, under the trees in charge of the nurses.

Many of the wards are open wards; that is, there are no bars on the windows and no means of restraint are visible. None is used except in the cases of excitement, and that restraint consists of continuous warm baths, electric cabinet baths, showers, and other hydrotherapeutic treatment given by the nurses. The hospital is well equipped to give such treatment wherever it is indicated.

Every mental hospital has some interesting types, and the Dayton State Hospital has its share of patients with strange delusions. One man, who was playing a game of croquet with some other men patients when I was passing through, seemed to be normal enough until the conversation turned to his absorbing delusion. He believes that he owns and controls the whole world. He told us that he had discharged the superintendent of the hospital at least four or five times, but that the man wouldn't go.

Another, a pretty young woman, of a harmless type, was sitting on the lawn making lace. She believed herself to be the possessor of ninety million dollars, all the stores in Dayton, and a lot of coaches made of pink satin and blue kid, with wax statues on the drivers' seats.

One woman about fifty years old was getting her lessons. She studies constantly, working out problems in arithmetic and exercises in Spanish and French and Latin.

The flower gardens furnish fresh flowers for the wards



Fig. 2. The rounded colonnade of white pillars around the entrance porch of Dayton State Hospital.

among the magazines which are taken by the hospital for the nurses' reading.

It is a pretty custom at Mount Carmel to name the corridors. There is a St. James' Hall and a St. John's and another named St. Angela.

Jefferson County Hospital, Fairfield, Iowa

The Jefferson County Hospital at Fairfield, Iowa, was opened for patients in October, 1912, and since that time has thoroughly proved the success of the community hospital built and maintained under a state law which provides that any county of the state must build and support its own hospital if the voters of that county say so. It has also proved that a hospital of this size and equipment, with the addition of such building changes as the growth in census and the progress in hospital service demands, is complete and adequate as first unit for the needs of a rural community of twenty thousand people.

The citizens of this county, conservative and more or less suspicious of new things, as those living in the isolation of rural communities always are, are bringing the members of their families, even unto the sixth and seventh, to its open door with confidence that they will receive needed help in time of illness.

The cost of building and equipping this type of hospital is comparatively small. This was met partly by the tax-paying farmers and merchants and partly by public subscription. The woman's auxiliary, lodges, societies, and individuals furnished part of the equipment, ambulance, and landscape gardening.

The total cost of land, buildings, and equipment was \$41,290.30. The average yearly expenditure of the hospital in normal times is about \$12,000, the cash receipts nearly \$10,000. The deficit is made up of the tax levied.

The Children's Hospital, Columbus, Ohio

In a charmingly situated residence building in Columbus, handicapped by the lack of some most ordinary necessities of hospital equipment, the Children's Hospital not only is

The hospital has been established for twenty-seven years. It has a capacity of fifty beds. Last year there were 714 children treated in the hospital and 1317 in the out-patient department. The hospital receives no pay patients. There are some which pay a small amount but the majority treated are free bed cases.



Fig. 4. A side view of the Children's Hospital, Columbus, Ohio. The children enter here for examination and treatment in the dispensary.

The income from a very large endowment will be available thirty years hence, when not many of those who are now laboring and struggling to make it a success will be alive to see it, but at present writing there is only an endowment of \$150,000 to support the hospital. It is in great need of new buildings and equipment, and there are hopes that at the close of the war some arrangement will be made to provide the necessary improvements.

The Children's Hospital furnishes clinical material in pediatrics for the State University Medical School at Columbus, and when a training school for nurses is maintained it affiliates with the Michael Reese Hospital of Chicago.

Miss L. D. Atkinson, the superintendent, has had especially good preparation for her work in pediatrics. She



Fig. 3. Making the rounds with Dr. Dickson L. Moore, who for over twenty years has given his services to the Children's Hospital.



Fig. 5. The back yard of the hospital on a pleasant day.

is a graduate of the Episcopal Hospital in Philadelphia and has had training in tuberculosis work and social service and in pediatrics at the Rockefeller Institute in New York.

The out-patient department employs its own visiting nurse. There are free dental clinics, and also clinics for eye, ear, nose, and throat as well as for the usual diseases of children. During the present shortage of nurses for hospital and clinical work, volunteer workers are assisting in the clinic and take the social histories of the children admitted to the out-patient department.

The Woman's Board of the Hospital gets out a little publication called the *Bambino*, from which we reproduce some pictures of the Children's Hospital.

giving motherly care to the sick babies and children entrusted to it, but is making thoroughly scientific diagnosis of the cases received and giving modern, approved methods of treatment in so far as the limitations of the hospital building and equipment will permit.



The
MODERN HOSPITAL

EDITORIAL AND PUBLICATION OFFICE.
58 East Washington Street, Chicago.

EDITORS.

Henry M. Hurd Fidelity Building, Baltimore
 Frederic A. Washburn . . . Mass. General Hospital, Boston
 Winford H. Smith . . . Johns Hopkins Hospital, Baltimore
 S. S. Goldwater Mt. Sinai Hospital, New York
 W. L. Babcock Grace Hospital, Detroit
 John A. Hornsby . . . 58 East Washington Street, Chicago

MANAGING EDITOR.

M. K. Chapin . . . 58 East Washington Street, Chicago

SUBSCRIPTION.

Domestic postage, \$3.00. Foreign postage, \$3.50 (15 Shillings). Single copies, 35 cents.
 Domestic rates include United States, Cuba, Mexico, Porto Rico, Canal Zone, Hawaii, and Philippines.

Contributors, subscribers, and readers will find important information on advertising page 42.

The Atlantic City Meeting

We mentioned last month some of the vital issues to be decided at the Atlantic City meeting of the American Hospital Association this month. We want to emphasize once more that it is a definite duty of all hospital administrators to be present at this very important meeting, if it is at all possible to do so. Not only is it a duty; it is an imperative necessity that hospital people attend in full force, prepared to give serious attention to the critical issues there to be considered. Moreover, Atlantic City is an ideal spot in which to spend a week's vacation, and those who attend will be well repaid in enjoyment and mental and physical refreshment as well as in the sense of duty done. The official program, together with much other information of interest, appears in the Special Bulletin of the American Hospital Association, page 227.

Enrollment by Physicians Not Suspended

The War Department recently issued a statement that volunteering and the receipt of candidates for officers' training camps from civil life were suspended until the pending legislation with regard to draft ages was disposed of and suitable regulations drawn up to cover the operation of the selective system under the new law. Fearing that the order might be misinterpreted by

physicians, Dr. Franklin Martin, chairman of the general medical board of the Council of National Defense, asked the Secretary of War to issue a statement making clear the distinction between enlistment as a private soldier and enrollment as an officer in the Medical Reserve Corps. Accordingly, the following statement has been issued:

"Orders issued by the War and Navy Departments on August 8 suspending further volunteering and the receipt of candidates for officers' training camps from civil life do not apply to the enrollment of physicians in the Medical Reserve Corps of the Army and the Reserve Force of the Navy. It is the desire of both departments that the enrollment of physicians should continue as actively as before so that the needs of both services may be effectively met."

In accordance with the request of the medical section of the Council of National Defense, we are glad to give publicity to the statement.

Hospitals and the Federal Inheritance Tax

The different war tax measures which have been introduced during the war period have more or less caused a certain amount of criticism, and perhaps no provision will work a greater injustice than the one which is incorporated in the Federal inheritance tax law, now up for consideration before the Ways and Means Committee of the House. Hitherto, the general rule has been to exclude from taxation all gifts acquired by bequests or inheritances to hospitals and other benevolent institutions. In the past, this has eliminated the large amount which would necessarily be deductible from any bequest or gift as inheritance and succession taxes on such bequest. Under the provisions of the proposed new law, hospitals which depend for their support wholly on private gifts and trusts will have a major portion of the tax to bear. The proposed law provides that, in the event of the bequest being paid out of the residuary estate, such payments shall not be made until all taxes and other expenditures have been liquidated. Under these circumstances, it will be very easily seen that the residuary legatee would bear practically all the expense attributable to the proper administration of the estate. This, of course, would not apply where a specific bequest has been made and a certain amount set aside for such bequests.

A strenuous effort has been made to remedy this injustice, by legislation prepared and submitted by Mr. Rainey for incorporation with the inheritance tax law. The whole crux of the matter is that the hospital, or such other benevolent institution, being the residuary legatee, would not only be paying the tax on its share of the bequest

granted it, but would also be paying the taxes of the other beneficiaries under the will. Should this law go into effect, there is no hesitancy in saying that many small institutions which depend on private charity for their maintenance and support would in a short while be forced to discontinue their operations. Nothing is more expedient at the present time than that the country be equipped with as many hospital facilities as possible, but with the passing of this law sooner or later a contingency would arise which, to a very marked degree, would hinder what the government is at the present time doing its utmost to establish.

The legislative committee of the American Hospital Association, which discusses the subject in the Bulletin of the American Hospital Association on another page, urges support of the remedial legislation provided by Mr. Rainey in H. R. 9223. The subject is one of the important topics which is to be considered at the Atlantic City meeting and is an additional reason for a full attendance at that meeting.

The Dietitian in Social Welfare Service

Not so long ago home economics was a subject about which very little was known and to which very little attention was given, even in the schools. Thoughtful people, however, gradually recognized the benefits to be derived from giving some attention to food. Now the vital part which diet plays in physical, mental, and moral fitness has been shown most conclusively by our medical men and nutrition experts.

So generally is this fact being accepted that new fields are constantly being opened to one who has made a study of foods and nutrition. A dietary department is an established part of every modern well-organized hospital. Many wholesale or manufacturing plants are asking women with this training to take charge of their lunch rooms or work with the nurse in their welfare department, or do both. Business men realize the economic value of having their employees so well nourished that they are less susceptible to pathogenic organisms which are so prevalent, and thus a minimum amount of time is lost because of illness. We have also learned that more and better work will be accomplished by a man or woman in good mental and physical condition than by one who is not.

Probably there is no place where there is a greater opportunity for doing valuable constructive dietetic work than in the field of social welfare. The wives and mothers in families of limited means and of our foreign population have

no means, except through civic organizations, of learning food values, the effect of cooking upon digestion of food, how to care for food materials, and how to market. Nurses as a rule are not competent to give this instruction. In some cities this is accomplished through a field dietitian. At this time, when every physician left to care for civilians is called upon to do the work which in normal times would be done by two or three men, a field dietitian could give invaluable aid and relieve him of much responsibility.

A great service is being rendered by a few hospitals which have dietitians in their dispensaries. This service is of far greater value if the dietitian can do the follow-up work in the homes.

The League for Preventive Work in Boston has recently opened a dietetic bureau. The establishment of this bureau is due to Mr. Michael Davis, director of the Boston Dispensary, who last year made a dietary study of families of limited means. Its purpose is to "bring dietetic knowledge of the highest type, through the case workers of social agencies down to the family of small income, in practical, every day working form." It will give this service to all agencies who make up the League for Preventive Work and to other organizations which may have need of this service. Though this bureau has been opened only a very short time, "many hospitals and dispensaries, settlements, and other associations are planning to coordinate their dietetic work with that of the bureau." Miss Lucy Gillette, who has been connected with the New York Association for Improving Conditions of the Poor, is directing the bureau. It is to be affiliated with Simmons College, and Miss Gillette will be a member of the Simmons Faculty. Senior students will be offered courses including field work in the bureau.

Other cities are introducing this work to a greater or less extent, and we expect soon to have several contributions on the subject in the Department of Dietetics. THE MODERN HOSPITAL would be very glad to have reports from others who are doing a similar work, whether from departments just established or perhaps from those only contemplated.

Once More the Army Nursing Question

Last month THE MODERN HOSPITAL based an appeal for nurses' aids on figures prepared over two months ago. These figures, it appears, were too conservative. Instead of a nursing organization of forty-five or fifty thousand women to supply an army of three million men, we need from

seventy-five to eighty thousand nurses to supply an army of five million men. If fifty thousand women were not forthcoming, where are we to look for seventy-five or eighty thousand?

Evidence was presented last month that nurses are needed now—that we cannot wait two years to train them. Additional evidence is now furnished by the army's appeal of August 7 for "one thousand nurses per week for eight weeks in order to provide with sufficient staffs of nurses the American army in France." An official dispatch from London, dated August 13, announces that recruiting has begun in England for a battalion of the Woman's Auxiliary Army Corps, five thousand strong, for service with the American expeditionary forces. Must America turn to hard-pressed England for such aid?

Officers of hospital units are authority for the statement that there are hospital units now ready to embark to which no nurses have yet been assigned. The chief of the Army Nurse Corps, in reply to an inquiry made by the secretary of the nursing committee of the Council of National Defense, explained the situation as follows: "The male personnel is sent ahead of the female nurses in some instances, due to transportation conditions and to the required time for the equipment of nurses." The army, the Red Cross, and any number of public or private patriotic agencies could, without delay, equip nurses available for service with these units—if the nurses were available.

One of the ablest hospital administrators in the United States, now commanding a base hospital in France, was quoted in these columns last month as saying that "the V.A.D.'s have certainly saved the day in the British nursing field," and that nurses' aids will have to help save the day in our war nursing field. Hospitals all over the country are preparing to train nurses' aids. Courses for such training are inevitable. Is it not best to recognize the fact and to standardize and regulate the courses while there is yet time?

The Enrollment of Senior Pupil Nurses for Military Service

A plan to relieve the nursing situation is suggested by a correspondent in this issue. The enrollment of senior nurses in the training schools for service in the military hospitals was one of the first methods proposed when the need of additional nursing resources first became apparent. If the training schools increase their forces now as rapidly as possible by the admission of large war classes, this program will be of great value about two years from now and will help to meet

the situation which will then exist. At the present time, however, Dr. Korndorfer's scheme has one very vulnerable point for criticism.

The enrollment of nurses for work under the Red Cross, in the army and navy, for relief work abroad, and for military hospitals here, has depleted and is still depleting the teaching and supervising forces of the civil hospitals. When the enrolled nurses have gone into the service, their places must, of necessity, be filled by senior pupil nurses. If these senior pupil nurses were taken, the civil hospitals would be in danger of serious disintegration.

For instance, the superintendent of the training school of one of the largest hospitals in New York City reports that, when she was absent recuperating after an illness, the base hospital unit of the institution was mustered into service. With it went sixteen of the supervising graduate nurses. On her return, this superintendent found herself obliged to run the nursing organization of that great institution with senior nurses in the supervising positions. What would have been the result to that hospital if these same senior nurses had been called to duty in the military hospitals? This story of shortage of supervising graduates repeats itself from all sorts of hospitals in various sections of the country.

From the military as well as the civil point of view, the needs of the civil hospital must not be forgotten. Unless our plans are comprehensive enough to take care of the needs of both civil and military establishments, we shall wake up later to find that we have committed an enormous military blunder.

A Plan for the First Unit of a Small Community Hospital

We publish among this month's leading articles a paper by Mr. Emmet E. Bailey, of Pittsburgh, on the projected community hospital at Brookville, Pa. We are calling attention to this paper chiefly because of the thoughtful, intelligent care which has evidently gone into its planning. It is possible that improvements might be suggested in the plans. For instance, we doubt the value of storage space under the roof if elevators do not run directly up there, inasmuch as the conveyance of packing boxes through the corridors is not conducive to a restful hospital atmosphere. And (though this scarcely comes within the architect's province) we question the advisability of giving so much space to laundry purposes, since general experience is against the laundering in the building of the linen supply of an average small hospital. These debatable points, how-

ever, are of minor importance. After all, the perfect hospital has yet to be built or planned. In general, we believe Mr. Bailey's plan to be a good one. With equally good organization and management, the little Brookville hospital should be able to render excellent service to the sick of the town and surrounding countryside. We should be glad to receive more papers in which the architectural plans are accompanied by a well-reasoned discussion of the considerations which led to the adoption of the distinctive features. This, we believe, is a very instructive method of presenting an architectural subject.

The Future of the Civil Hospitals

The experience of Canadian hospitals furnishes an object lesson which this country may study with profit. The following, headed "An Appeal for Nurses," appeared in the July issue of *Reconstruction*, the bulletin of the Canadian Department of Soldier's Civil Reestablishment:

"One of the consequences of the war is the deserted condition of the schools of nursing. It is stated by hospital authorities that the time will soon come when hospital doors will have to be closed or arrangements made whereby patients can be cared for by their relatives. Hospital authorities are considering the wisdom of issuing an extensive appeal to the young women of Canada to take up the nursing profession by enrolling in the various schools of nursing, most of which are conducted in conjunction with general hospitals. So many of the trained nurses have gone into military service that the civilian hospitals find it most difficult to keep this important branch of their staffs fully manned."

The Modern Hospital—Prospect and Retrospect

We announced last month the removal of our business offices from St. Louis to Chicago. It may be of some interest at this time to explain just what this change means to THE MODERN HOSPITAL and its readers.

The consolidation of the editorial and business offices of THE MODERN HOSPITAL under one roof and certain other changes consequent on or coincident with that centralization are the result of plans running back almost to the time of the foundation of this journal. Some of these plans are now in the process of fulfillment; we still look forward to the realization of others. THE MODERN HOSPITAL is developing along the lines laid down for it at its inception; it has changed only in the sense that everything alive and growing must change.

We mentioned last month the double advantage which was expected to accrue from closer co-operation between the editorial and statistical departments. It has been the aim of the statistical department to serve the hospitals by furnishing

any information that may be useful to them. The data on the hospitals of the country, their bed capacity, character of work done, connection with training schools, etc., compiled by Mr. H. T. McClure, head of this department, are more complete and trustworthy than any to be found elsewhere. The statistical department has had the privilege of furnishing data on the building of hospitals to the medical section of the Council of National Defense; of collecting for the Red Cross information with regard to hospital executives available for war service; and of furnishing information to the American College of Surgeons for use in its hospital standardization campaign.

Several of the departments of THE MODERN HOSPITAL are planning extensions of activity. In the Department of Nursing, Miss Goodrich, whose time and energies are naturally absorbed to a considerable extent by her duties as dean of the new Army School of Nursing, has felt the need of a coadjutor, and Miss Carolyn E. Gray, principal of the City Hospital School of Nursing, New York City, has accepted this position. Miss Graves, editor of the Department of Dietetics, intends soon to inaugurate a new feature which will, it is believed, very greatly increase the value of this department to its readers. She will answer questions of general interest to dietitians, superintendents, etc., through the columns of this journal. The Department of Industrial Welfare, under its editor, Mr. Barrow B. Lyons, superintendent of Delaware Hospital, will take up many important questions. Mr. J. J. Weber, recently appointed eastern editorial representative of THE MODERN HOSPITAL, is giving special attention to New England hospitals and dispensaries.

Dr. Hornsby and several of his associates on the editorial board are for the present devoting themselves to the service of the government. It is, of course, a privilege for THE MODERN HOSPITAL, not less than for the individuals concerned, to be permitted to make some sacrifice for the common cause; even if it meant being deprived altogether of the invaluable guidance of these hospital experts, we should have no right to do otherwise than cheerfully and gladly to resign our claim to their services. Fortunately, however, this degree of abnegation has not been demanded of us; we are still able, from time to time, to avail ourselves of their advice and counsel. The policies of THE MODERN HOSPITAL, consequently, are still directed by members of the editorial board.

The summons into government service of members of the editorial staff has, however, accentuated a condition which existed previously and

has hastened the application of a remedial measure. With the growth of THE MODERN HOSPITAL, it had become increasingly difficult or impossible for Dr. Hornsby to give his personal attention to the multitude of details connected with the editing of the journal, and his more or less protracted absences from Chicago on government service seemed to require the appointment of a managing editor, to conduct the details of editorial affairs. Miss M. K. Chapin, previously associate editor, has been appointed to this post.

Many other interesting new activities or extensions of old activities are contemplated, and further announcements will be made from time to time.

Spontaneous Combustion of Coal

Spontaneous combustion of coal usually occurs in very fine coal, or coal with a great deal of dust and fine particles in it. Chestnut, pea, or any well-screened coal does not ignite, nor does coal which is so spread out that the air can penetrate freely to all parts of the pile. As war conditions have made it necessary for users of coal to take what they can get, and as storage space in cities is limited, spontaneous combustion is likely to occur frequently, and, in fact, we understand that fires from this cause are increasing. Hospitals and other institutions should watch the temperature of their coal piles. The fire department of the city of Chicago has offered its services free to coal users, who are invited to report any suspicious rise in temperature. No doubt the fire departments in other cities would be equally glad to cooperate for the prevention of fires.

Wanted—Stories of Hospital Life

We have long wished that THE MODERN HOSPITAL might be instrumental in encouraging hospital people to write some of the incidents—amusing, pathetic, or dramatic—of institutional life. A few of these are recorded in the series of "Memoirs of a Head Nurse," which began in the June issue of this journal. Every hospital, however, has its stories. We would like to receive these narratives from institutions all over the country, and we desire especially to hear from nurses. While we do not place any absolute limitations of length on contributions, from five hundred to a thousand words will be an acceptable average length. Names, of course, may be altered, and incidents disguised if they would give a clue to identities. To mark our appreciation, we shall be glad to credit the author of any article accepted with a year's subscription to THE MODERN HOSPITAL.

To all who may know interesting tales of hospital life, but who are reluctant to write because their previous experience has been practical rather than literary, we wish to say: The story's the thing; let it tell itself; never mind the fine writing. And, in sending it in, please indicate whether the writer is a superintendent, a physician, or a nurse, and, if a nurse, whether graduate or undergraduate. These particulars will not affect the acceptance of the article; the information is asked for merely as an item of interest.

THE LATCHSTRING OUT

THE MODERN HOSPITAL will take great pleasure in being of service to out-of-town hospital people on their visits to Chicago. We hope that our friends will come to us for any information that we can supply in regard to the city or in regard to local hospitals. News which they can bring us in regard to work in their own communities is of interest to our readers, and will be published in this column from time to time.

A WONDERFUL work for the blind was lately described to us by Mrs. Sidney McCallin, an American recently returned from London, where she served for over a year on the staff of St. Dunstan's Hostel. There is nothing like St. Dunstan's in the world. It was founded by Sir Arthur Pearson, the publisher, who is himself blind; it embodies the new ideas with regard to those who have lost their sight.

Mrs. McCallin says that, when she first became a member of the staff of St. Dunstan's, she was surprised to find



Fig. 1. Members of the staff of St. Dunstan's Hostel.

that she was not depressed by association with these unfortunates. "Am I growing callous and unfeeling?" she asked herself. On analyzing the situation, she found that the men themselves were the happiest crowd with whom she had ever come in contact. They do not regard themselves as objects of pity; far from it. "I'm not handicapped, sister; I'm only blind," one or another would say.

St. Dunstan's Hostel (not hospital) receives the men after their physical rehabilitation is complete, and shelters and trains them until they are ready to go out into the world as self-sustaining members of society. They usually remain about a year, but they may stay longer.

Because they are no longer subject to the distractions which enter through the avenue of sight, they learn much more quickly than do persons who see, and, when they leave St. Dunstan's, they are often prepared to earn a better living than when they had their sight. They are



Fig. 2. Wedding of a blind soldier, a guest of St. Dunstan's Hostel, who has never seen his bride.

not, however, flung overboard to sink or swim; St. Dunstan's still has a watchful eye and a friendly hand for all of its graduates. Mrs. McCallin has kindly written something for *THE MODERN HOSPITAL* about her work at St. Dunstan's, which will appear in an early issue.

KANSAS is living up to its progressive reputation, reports Dr. Lydia Allen DeVilbiss, chief of the division of child hygiene, State Board of Health, Topeka. The two most important pieces of work at present being accomplished by her division are a state-wide house-to-house canvass of mothers and a centralization of the care of dependent children. The five-blank system is used in the state-wide canvass of mothers. The first blank is for the mothers who wish to receive the Kansas Mothers' Book free; the second, in regard to the birth registration test; the third is the pre-natal blank (the expectant mothers receive a series of nine monthly letters from the State Board of Health); the fourth, information concerning the care of crippled, defective and dependent children; and the fifth, in regard to communicable diseases. Two counties have already been covered by the canvass and it is being carried on in twenty others.

Incidentally, Dr. DeVilbiss says that Kansas has gone further than most other states in its clean-up for the benefit of the young soldier. Kansas quarantines not only women, but men, affected with venereal diseases.

MR. JOHN G. BOWMAN, director of the American College of Surgeons, who has recently returned from a trip through eastern Canada, has brought back very favorable impressions in regard to Canadian hospitals. Canadian hospital administrators, according to his observation, are most desirous to improve and welcome constructive suggestions. Many of the hospitals under the direction of various sisterhoods show most creditable progress.

Mr. Bowman reports that the American College of Surgeons will call a conference of Fellows of the college and leading hospital administrators to be held in New York in October, at which the work already done by the college will be reported and plans worked out for a further campaign.

DR. HUGO EHRENFEST, of St. Louis, says that the war has caused the usual amount of disorganization in the City Hospital of St. Louis. The service there was organized in three units, one-third of the patients being allotted to Washington University, one-third to St. Louis University and one-third to unattached physicians. This third unit has been practically broken up. Dr. Ehrenfest believes, however, that there is no need to be pessimistic about the future of the civilian population; the patients who really need care will be taken care of, while those who have indulged in the luxury of a physician and a nurse for every trifling ache or pain will have to do without.

MR. JOSEPH PURVIS, superintendent of West Suburban Hospital, Oak Park, Ill. (described in the "Field Editors' Notebooks" for August), has recently accepted an administrative hospital position with the American Red Cross, and expects to be assigned to duty soon.

Why Hospital Standardization?

There are in New York quite a number of small hospitals fashioned out of one or more of the old brick or brownstone front rows in the older part of the city. Some of these are hardly up to our present ideas of sanitation or efficiency. Recently an investigator reported conditions in one of these institutions which we believe will show as good a picture of the hospital standard as any end-result or case record. In one small room were found three crib beds. The first contained a new-born baby, so new that it had not yet had its first bath; the second held a child who had a bad case of erysipelas, and on the third was laid to dry a batch of noodles for that day's dinner!

Building of Permanent Tuberculosis Hospitals Approved

"The National Tuberculosis Association announces," says a recent issue of the *Survey*, "that there is pressing need throughout the United States for an immediate increase of hospital facilities for the tuberculous. It is cooperating with the Capital Issues Committee of the Federal Reserve Board to secure the necessary capital. To allay uneasiness in certain quarters, this board recently announced that, in spite of the necessary conservation of the capital for war purposes, the building of hospitals will not be limited to temporary structures, but that investments in permanent structures will be approved if the difference in costs is not too large, or if special circumstances make them more desirable."

Saving in Adoption of Food Administration Measure

The Michigan State Prison reports large savings in feeding its twelve hundred inmates through adoption of Food Administration measures. There are two meatless and wheatless days every week, according to the report of Steward G. W. Wenzel to the Michigan Federal Food Administrator. Fifteen per cent potatoes are used in baking wheat bread, and this has been found so satisfactory a substitute for wheat flour that the percentage is to be increased. Some difficulty was found in purchasing cereal substitutes, so the prison bought a carload of corn and installed a mill for grinding meal.

He who sincerely serves his country leaves the fragrance of a good name to a hundred ages; he who does not leaves a name that stinks for tens of thousands of years.—An Emperor of China.

THE GLENNAN ADJUSTABLE BUNK

A Comfortable Hospital Train Bed for the Sick and Wounded—Flexibility of Adjustment

By HARRY N. KERNS, Major Medical Corps, U. S. A.

The transportation of sick and wounded presents no problem more difficult than that of providing for the unexpected. The two questions which will always be asked by the transportation division are, "What kind of accommodation is needed?" and "What amount will be required?" It is true that experiences gained from recent warfare have taught us to expect a certain percentage of the total number engaged in battle

to result in casualties, and we have further learned that these casualties may be divided into three types: (a) those able to walk, (b) those requiring ambulant transportation, and (c) those who must be transported in the recumbent position. As to the relative proportion in which each one of these three types of casualties will be encountered, we may make a forecast, but our estimates are at best only approximations

and, as such, are subject to very wide variation. Transportation facilities, then, must be so flexible as to meet any demands which ever-changing conditions may indicate.

In the field, our problem has apparently been solved by the ambulance. Both the motor-driven and animal-drawn vehicles are so equipped as to provide for either the lying or sitting patient.

The next link in our line of communications is the hospital train. Here it may be suggested that the Pullman section, with its readily convertible features, should meet all requirements, and for the convalescent case it is really ideal. But for the bed case the Pullman berth leaves much to be desired. Furthermore, the constantly increasing demands of troop transportation in this country have drawn heavily upon the available Pullman cars, so that to withdraw them in any considerable number for use of Hospital Trains would be to embarrass troop movements.

Some scheme had to be devised embracing a convertible bed, one which could be used for either recumbent or ambulant patients, and which could be readily applied to any type of car: the Pullman car, the ordinary day coach, or the freight car.

To meet this situation, Col. James L. Glennan and Lieut.-Col. William L. Hart have devised an adjustable

bunk. The mechanical details were worked out by the Simmons Metal Bed Company.

In a general way, this bunk corresponds to the one now in use on the British hospital trains, but many changes and improvements have been made.

The Glennan bunk is capable of four adjustments, all of which are shown in the accompanying illustrations. It will be seen that the vertical steel stanchions which support this bunk are applied to the wall of the room. They may be applied to the side of a car in the same manner, irrespective of window spacings.

Figure 1 shows the position in which it will ordinarily be used for recumbent cases. As the bed is but 2½ feet wide, it seemed desirable, particularly in the case of the "upper," to provide a retaining strap which would safeguard the patient from falling out. The position and attachments of this strap are readily seen in the picture. An ordinary wooden head-board has been provided. This is partially obscured in the illustration by the pillow, for which it forms a support.

Figure 2 shows the bed dropped to a more convenient mid-elevation for cases requiring extensive dressings or other special treatment. The bed in this position is 36 inches high. The lower bed will be seen folded up out of the way.

A sofa position is shown in Figure 3. Here the upper bed is simply dropped down to form the back rest, no adjustment being necessary for the lower bed, which forms the seat. The mattress, secured to the springs by straps, forms the back of the sofa. In the other positions the same straps serve to retain the patient. The sofa will comfortably accommodate three ambulant patients, though for long trips it is not recommended for more than two.

When not in use, both beds may be folded up against the side of the car to facilitate cleaning (Fig. 4).

The bed itself may be completely detached from its supports and used as a litter, should such procedure be indicated in the transportation of those patients so seriously ill that the minimum of handling is desired.

The adjustments required in the conversion of the Glennan bunk into its various positions are easily and quickly made. Two men are required for this purpose, but, after a little practice, it is believed the changes may be made more quickly than in the case of a Pullman.

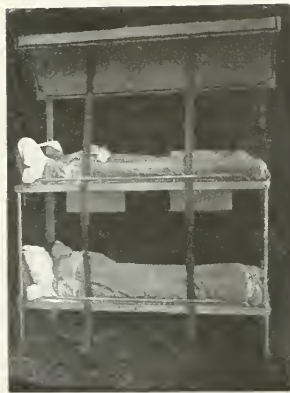


Fig. 1. The Glennan bunk in position in which it will ordinarily be used for recumbent patients.



Fig. 2. The bunk with the bed dropped to a more convenient elevation for cases requiring extensive dressing or other such treatment. The patient is using the Hart server.



Fig. 3. The Glennan bunk in a sofa position, the upper bed being dropped down to form the back rest. The two patients are making use of the Hart and the Travis servers.

To provide for the serving of food to patients in this bunk, an arrangement has been devised by Col. W. L. Hart, M. C., to take the place of the medical department "tray with legs," the latter having proved quite unsatisfactory on Hospital Train No. 1. The Hart "server" consists of an ordinary tray fastened to an inverted L-shaped supporting rod, the vertical leg of which is shaped to fit snugly into a tapering square hold on the side of the bed. It may be used for either bed or sofa, by simply rotating the L rod 90 degrees on its vertical axis so that the tray may be brought across the bed or over the edge of the sofa. The tray itself may be converted into a book-rest for the recumbent patient by rotating it 45 degrees on the horizontal axis. Figure 3 furnishes a very good idea of the varied uses of this server, while Figure 4 shows the way in which the beds may be folded up when it is necessary to clean the car.

The Glennan bunk has been put to the test of actual usage on two occasions in transportation of overseas soldiers convalescent from serious wounds. These cases were of varying type and severity, and, while the bunk appeared to meet the needs of each in a satisfactory manner, more extended use will undoubtedly indicate lines along which improvements may be made. It is not as comfortable for the ambulant case as the Pullman section, but it is vastly more flexible, and the accommodation it provides for the recumbent case is almost as good as that of the standard hospital bed. It is substantially built, relatively cheap, and may be readily installed in barracks, hospital, ship, or any type of railroad car. It embodies a degree of flexibility which will go a long way toward providing for the unforeseen.

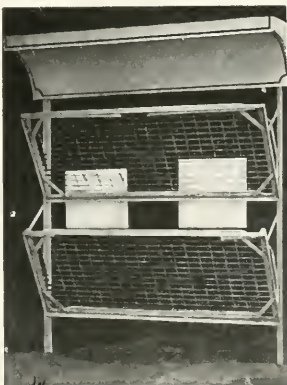


Fig. 4. The two beds folded up against the side of the car to facilitate cleaning.

A SIX HUNDRED-BED HOSPITAL TENT PREPARED IN TWENTY-FIVE DAYS

Site Was Once a Race-Track for Sport, Now a "Wayside Inn" of Mercy—Regular Hospital Conveniences Offered at the Front—Tents Easily Transported as Troops Are Moved

By FORBES WATSON of the American Red Cross, Paris.

It took the American Red Cross just twenty-five days to transport a 600-bed hospital to a once famous race course near the front, and set it up ready to receive the wounded.

At three o'clock on the morning of the twenty-fifth day, ambulances began to arrive with gassed Americans, and

To those who have not visited the modern army tent hospital, such an institution may seem to be a kind of makeshift where the wounded soldier is taken care of as well as the circumstances permit, but is not really getting the benefit of a complete hospital installation. This is an entire misconception. The tent hospital is not a casual incomplete affair. It has a steam-heated operating room which can be placed on a specially made truck for rapid transportation. It has a complete sterilizing plant also attached to a trailer which is pushed up to the operating room in such a manner that the sterilized instruments can be passed from the nurse to the operating surgeon without loss of time. It has a fumigating plant, shower baths for wounded able to take baths themselves, bath-tubs for those so sick that they have to be given their baths, a complete electric lighting system, and stoves to keep the wards warm in cold weather.

It is divided into wards of twenty-four beds, each ward being 60 by 20 feet, and there are covered connecting passage-ways wherever necessary. The kitchen equipment is complete for patients and personnel. And, finally, the wards are cool in summer and warm in winter. The tents are the well-known Bessonneau type, with windows that make them light and airy, and an air-chamber between the two coverings of the tent. This hospital is as comfortable for the men as a permanent installation.

Hospitals of this type are known as *autochairs*, a word that has been coined and is now generally used, being a contraction of the two words "automobile" and "chirurgicale." Generally they are divided into units of two hundred beds which can be moved on eighteen trucks. When all the items of equipment are properly packed and in the right places and the personnel are trained in the work, they can be set up with about the same speed as a circus. The illustrations indicate the type of hospital resulting.

In fact, the great advantage of the tent hospital is the speed with which it can be installed and removed. When used at the front, it is pushed forward to the farthest practical point, and in case of a withdrawal of troops, it is possible to move the hospital back before it is captured. Similarly, when there is an advance, it can be moved up toward the new lines.

But when the Red Cross establishes a tent hospital, such as the present, the object is to supply an emergency



Fig. 1. Beams, flooring and canvas for a tent hospital which the American Red Cross completed in twenty-five days and turned over to the Army Medical Corps.



Fig. 2. This hospital for six hundred American soldiers was ready for patients twenty-five days after the site had been selected.

before the close of the day, one hundred sixty wounded were being cared for. The work was done at the request of the United States Army, and the hospital has been turned over to the Army Medical Corps.

demand for hospital accommodations. However, there is no expectation of hurried moving, so that permanent barracks of various kinds supplement the tent installation. Tents are economical in time, and last for two or three

years, if kept in the same place, but after they have been subjected to the weather for six or eight months in the same place, they cannot be moved without a good deal of wastage, due to shrinking, stretching, etc.

The present hospital is not for serious cases; it is used for those that can be evacuated in ten days or two weeks. They are either sent back to the front, cured, or evacuated further south to hospitals for long cases. The wounded coming to this hospital have already been treated at a base or field hospital, and then moved to make room there for other incoming wounded. It would be a waste of time to send men who will soon become effective to hospitals distant from the front. At the same time, it is a cardinal principle of army hospitalization to guard against any chance of having base and field hospitals overcrowded in times of crisis. Hence the half-way station, which is what the present hospital might be called.

The present location is ideal for such a hospital. On a piece of ground surrounded by woods, the land is high enough and sunny enough, yet all about there are comfortable shady places for the boys who can move about. One who was there yesterday had taken part in the successful attack on Cantigny. He was the victim of a gas attack, but a mild case, and when Cantigny was mentioned, he grinned.

"Yes," he admitted with his face almost submerged in a big bowl of milk, "we licked 'em."

And there was another boy who was wounded by a machine-gun bullet which had just touched the tip of his nose and gone through his clothes at two different places without doing any more damage. He wore two wrist watches. The one on his right wrist belonged to his lieutenant who was shot at his side. Just before being shot the lieutenant said: "Bill, if anything happens to me, take care of my wrist watch"; and Bill did.

Very different is the chance these men are taking from the chance that the men used to take in this field. Yes, the old betting booths are still there, but they are filled with bales of hospital supplies, and the little thatched-roof meeting place for bettors is now a smoking and afternoon-tea pavilion for United States army convalescents. The hurdles are almost hidden in the tall grass. The names of the horses are washed off the betting board, but the race-course never had as many thoroughbreds as it has today. And the thoroughbreds, being United States soldiers, are exactly the kind that the American Red Cross is most interested in taking care of.

THE MEMOIRS OF A HEAD NURSE

IV. Peter Koksovidus—The Operating Room Supervisor Tells This Tragedy of the Police Ambulance

Bill Black was standing by the big window in the long hall that led into the emergency rooms of the operating wing. The window was just opposite the elevator and looked down into a court where there was a cement incline to the ambulance entrance.

Bill was initiating a new orderly in the proper methods of receiving emergency cases. He was always appointed a committee of one to pass on the applications for admittance of orderlies to the fellowship of the operating rooms, and his judgment never failed.

After two or three days' trial of each new man the supervisor would ask, "What do you think of that new orderly, Bill?" and Bill would invariably give one or the other of the two following answers: "E's h'absolutely 'opeless, miss," or "E's a poor nut, miss, but if ye gives me time, I thinks as 'ow I can get it through 'is dome."

Besides his native cockney English dialect, Bill possessed a good vocabulary of one other, the most forcible and expressive dialect known to any language, American slang, and he used it whenever and wherever possible.

The new orderly was listening attentively to his instructor. "Listen," said Bill. "When the h'ambulance whistle is blowin' nice an' easy, ye don't 'ave to 'urry yerself, but when she comes the way she's comin' now like h'all 'ell was let loose, she's got a bad one inside. Watch for yer h'elevator. Sometimes she don't come up at all. Then yer know it ain't no use, they takes 'em to the morgue. Stand by, this time she's comin' up."

The elevator door swung open, and out came two police ambulance men carrying a stretcher, on it a gray-faced, dark-eyed laborer in overalls. His life was oozing through the thick canvas of the stretcher, wetting the policemen's shoes and leaving a red trail on the white-tiled floor.

I think I shall live to be very old before I can forget Peter Koksovidus. Peter was a Greek with a profile as clean-cut as a marble head of Apollo. He had thick black curls and wonderful chest muscles. Most of Peter we put on the emergency table; the rest of him was in his boots which the motorcycle policeman was carefully setting on the floor. Peter had tried to cross the tracks in front of a Grand Trunk switch engine.

For once there were plenty of interns on hand. The shrill shrieking of the ambulance whistle had brought at a run even those who were having their afternoon naps, or talking in corners to their favorite nurses.

Someone had called the office for one of the staff. The senior surgeon himself happened to be in the house and came up—a great surgeon, a kindly and courteous gentleman of the old school. He stood at a distance from the table with his hands in his pocket. I wondered then why he did not put on a gown and help us or suggest something. I know now that he saw at a glance that our work would be for nothing, but he liked to watch us while we made the good fight.

The resident physician stood on the left of the table giving a subcutaneous saline in the breast. I was on the right giving hypodermics about as fast as a nurse could get them ready for me, but in spite of all this, and in spite of the good, quick work that two junior interns were doing, tying the bleeders, lucky Peter was going out, slowly but surely, under our hands, saying over and over again just one Greek word I couldn't understand.

I asked the interpreter what he was trying to say and he answered, "Oh, he just say, 'why?' 'why?' all the time."

The senior surgeon said to a group of interns as he passed out the door, "To do emergency surgery one has to be something of a philosopher. Good night, gentlemen."

MENTAL HYGIENE AND THE WAR

Mental as Well as Physical Preparedness Provided for in Our Government's War Program

By ETHEL ANDERSON PRINCE, Assistant Secretary, New York Committee on Feeble-Mindedness, New York

Some years ago there was coined a term which today is firmly established even in the vocabulary of the layman. Theoretically we have long believed in *mens sana in corpore sano*, but it remained for the last decade to see mental hygiene standing shoulder to shoulder with widespread endeavors for nation-wide physical and moral betterment. It was inevitable that it should be so; for if we grant one of our final goals to be an ever-increasing social adaptation, certainly we must recognize the part

played by mental factors in cases of failure of adjustment and guard against them. We have long recognized the preponderance of these factors in work with the mentally sick. Of late we have realized the necessity for constantly applying our wider knowledge of the mechanisms of the mind in any organized prophylaxis—in the school, the factory, the juvenile courts, the prison. And today, because therein are mingled all the varied factors of human behavior, all potentialities for future good or ill, we must admit a new and challenging sphere for mental hygiene—the great war.

For the first time in the history of the world a nation has gone into war with a realization of the need for mentally, as well as physically, fit soldiers. Success has always been predicated on strength. The leaders of a people have ever included in that category physical strength and that definition-eluding spiritual strength, or morale. The great war has added another prerequisite to victory—mental strength—without which neither of the other two avails.

It was a source of much gratification to mental hygiene workers generally when it became apparent that the government was fully pledged to a war program which included provision for mental as well as physical preparedness. This program was largely the result of the most intensive kind of preparedness on the part of the National Committee for Mental Hygiene. In April, 1917, a war work committee was established with Dr. Thomas W. Salmon, the medical director of the national committee, as chairman, Dr. Pearce Bailey and Dr. Stewart Paton being the other members.

In May, 1917, Dr. Salmon went abroad and made a special study of the war neuroses and mental disorders in the British Army. His report has been of utmost and basic assistance to the Surgeon General in making plans for psychiatric work in the American Army. A division of psychiatry, neurology and psychology in the Medical Corps was created with a three-fold purpose—to eliminate from the service the mentally and nervously unfit, to provide for the care and treatment of cases of potential and actual incapacity, and to undertake the problem of reconstruction and return to the army or civil life of the mentally or nervously disabled. Col. Pearce Bailey is director of the division, with Maj. Robert M. Yerkes as head of the psychological section. Dr. Salmon, with the commission of lieutenant-colonel, is in charge of the neuropsychiatric work of the American expeditionary forces in France.

At once there was a fundamental need for psychiatrists and neurologists, and the call has been answered up to date by about four hundred and fifty men, who have in most cases taken out commissions for the duration of the war and are ready, the pick of the profession, to officer this line of defense. Some have gone overseas with base and evacuation hospitals, some are in charge of instruction work here, while others are looking after returned soldiers suffering from nervous disorders. Each cantonment base hospital is supplied with a neuropsychiatric ward, and in addition five larger psychopathic hospitals have been established in the areas of densest military population. A thousand-bed special base hospital for war neuroses has been established in France.

A large number of the officers in this division are engaged in running the machinery of exclusion from the army of the mentally and nervously disabled. This is the popular appeal. We have read much of "instantaneous mental diagnosis" in the current dailies. Formerly, to the lay mind a mental examination sounded like either a pleasantly innocuous game or a series of absurdities.

But the public has become accustomed to the idea and on the whole more tolerant. We could hardly ignore the fact that up to July 1 of this year twenty-two thousand men have been recommended for discharge from our army for mental or nervous troubles or detailed for domestic service only.

It was evident, with this great number excluded from our available fighting strength, that we must take some strong measures for prevention in the case of the potentially psychotic and neurotic and for treatment for the actually incapacitated. Special neuropsychiatric wards have been established and attached to base and evacuation hospitals. A skilled nursing personnel has been recruited, as well as expert occupational and special workers for reconstruction work with returned cases. Effort to get the various states to cooperate in caring for the men returned from camps as unfit for service so far has enlisted the help of forty-four states.

That mental hygiene is a practical necessity, in war as in peace, is becoming more established in public thought. Smith College is offering a course for the intensive training of "psychiatric social workers" with special reference to occupational and reconstruction work with mentally disabled soldiers and their families, but with a larger future program in civil life. The women in training as nurses at Vassar College this summer are being given instruction along lines of mental as well as physical hygiene. Courses embracing this field are announced for the summer session at Columbia University, including occupational therapy, social investigation, etc.

The increase in abnormal mental manifestations during war is very marked. We were somewhat accustomed to the size of the figures in peace times; we knew that we must expect fifteen hundred insane a year from an army of half a million in days of peace. We know today from the statistics of our allies that we must expect over three times that number from half a million sent on the field. Even tuberculosis does not approach mental disorder in its importance as cause of permanent disability in military service. The unparalleled conditions of strain and stress produce an unprecedented number of insane and neurotic. Even during the summer of 1916 when our troops were on the Mexican border mental disorders led in the causes of discharge. In the Canadian Army mental disorders represent one-tenth of the total casualties. British statistics show that mental and functional nervous diseases are responsible for not less than one-seventh of the discharges for disability from the army, or one-third, if the wounded are excluded.

In peace times mental disorders among troops show a fairly high rate of recovery, and in the war neuroses even a greater degree of quick return to normal seems to be present. This is especially true of the so-called "shell-shock." But while admitting this optimistic probability, we must realize that only in immediate treatment, if possible within the sound of artillery, lies our best chance for good results. We must have not merely adequate detention facilities at base hospitals; we must have first-rate psychiatrists and nurses. The first desideratum in the eyes of the commanding officer at present is naturally to get a disabled man back into the trenches. Hence prompt and efficient treatment at base or field hospitals—which results often in immediate return to the colors. For, especially with the functional nervous disorders, give the right kind of first aid, recovery is sometimes instantaneous and complete. Failing that, there is the special overseas hospital with wards for nervous and mental cases, followed by care at a special convalescent camp. Returns to the ranks may be made from here.

But inevitably some patients, either incurable or requiring longer treatment, must be sent home. So there is a need for a clearing house at the port of entry where cases may be classified, social investigations carried on and adequate measures for disposition in general or special hospitals, convalescent camps and re-education centers taken.

It is not merely what the war has done for mental hygiene in public acknowledgment, as one writer puts it, "that mental hygiene has 'arrived,' that organized work to promote mental health is no longer an experiment, but has become a vital part of all public health work and is contributing to national stability and supremacy." Here we have direct evidence of the value of what mental hygiene has done and is doing for the war. With emotions strained taut to the breaking point, with constant need for action, demanding the keenest mental and bodily reactions, we are realizing that the goal of victory depends not only on the physical stamina of him who runs the race but on the brains he possesses also.

But while we are striving to give the best that is in us to this world-wide struggle for the safety of democracy, we must not fail to keep our program for the future ever clear before us. We have a two-fold task imposed. First win the war, then, and no whit less urgent, we must prepare to assist in restoring conditions favorable to normal thought and action. And since the democracy we hope for includes a milieu sane and healthy, we must prepare for a more efficient and intelligent organization of social forces than we have heretofore seen. We may find it a far more challenging task to successfully prosecute the right kind of peace than a successful war.

THE TRAINED ATTENDANT*

The Problem of the Small Hospital—The Trained Attendant Versus the Untrained Practical Nurse

By FLORENCE DAKIN, R.N., Superintendent Middletown Hospital, Middletown, Ohio

That there is an absolute necessity for meeting the present need for nursing care is evident. Any plan which may assist in solving this vital problem should be considered with an open mind, and all suggestions should be thoroughly investigated before being condemned.

One particular branch of hospital training, that of the trained attendant, offers one solution. Up to the present, trained attendants have been connected chiefly with short, theoretical courses given in insane asylums, homes for incurables or convalescents, or special institutions, such as eye and ear hospitals.

It is the employment of the attendant in the general hospital that I wish to emphasize, and I would like to explain that statement at once so that it may not be misunderstood. We have two great classes of people who do nursing—the trained or graduate nurse and the untrained or practical nurse. The latter is as essential and important as the former, and has as necessary a work to do; perhaps, in a way, more, since the lives of those who employ her are often jeopardized by want of care, or misdirected care.

Many of those who require or prefer practical nurses are not able for various reasons to go to hospitals, particularly when there are none very near, even if they could afford to do so. Mothers cannot always leave their families uncared for and cannot or do not wish to send

their children alone for hospital care. The practical nurse is best adapted for such cases, particularly when the duties entail a little housework, perhaps, or the absence of modern conveniences. Then, also, in country cases, the country practitioner is frequently unused to the graduate nurse and advises the practical nurse, as conforming more to his desires as well as to those of his patient. So, whether we will or no, we have the practical nurse with us, and she always will be with us, with her good or bad experience instead of training, until we can present a proper substitute.

The term "trained attendant" is aptly chosen, for while it does not transgress upon the ideals incorporated in the word "nurse"—those ideals which we wish to and must keep intact—it implies that there has been training under supervision. The number of so-called correspondence schools is overwhelmingly large, and the type of woman "who does nursing for Dr. So-and-so" abounds. In 1917 there were over seven hundred of these women in New York State alone. The crying need of the great war nursing problem has brought into existence another class—the nurse's aid or untrained woman who can give perhaps a few months to a short course of training.

Before arriving at my point I must speak of training schools in general and those connected with small hospitals, in particular. The higher educational standards the former maintains the better, and even the visioning outline of the future university training center, as suggested at the recent nurses' convention at Cleveland, Ohio, by Col. Winford H. Smith, reveals to us not only a possibility but a reasonable probability as well. We cannot have too high an ideal for our profession, but we must not blind ourselves to what we are leaving behind when we are on the upward trend.

The large schools are being better and better equipped. More resident instructors are installed, and larger opportunities are given to the pupil nurse. All these improvements bear directly upon the small hospital with its training school of from six to fifteen nurses. The small hospital, in many states, has to meet its lack of service by affiliation with larger schools and, therefore, has to support more nurses than it is using for its own need.

The larger schools have so much more to offer in service, equipment, and instruction, that there is a shortage in applicants in small hospitals, though often the requirements, educational and otherwise, are the same.

This brings us to two vital questions. The first is: Should we urge young women, who are qualified to meet higher requirements, to give two or three years of their lives to an institution which cannot provide training sufficient to equip its graduates for institutional work or provide a field for private practice, and which compels its graduates in a struggle for a recognized place to take a post-graduate course in a better-known hospital? It is certainly not fair to the young woman herself, for we are thereby, perhaps unconsciously, depriving her of the opportunity she should have, if she has the required qualifications and if she is willing to give the time and strength to her profession.

The second question is: Is it fair to the larger schools (in hospitals of from fifty to one hundred beds and upwards) to reduce their number of applicants by supplying qualified applicants for these numerous small schools which exist all over the country? The very large hospitals and well-known schools are perhaps never short of applicants, particularly at the present time; but there are as many, if not more, medium-sized schools which find it difficult to keep up their required quota of probationers.

*Read at the annual meeting of the Ohio State Hospital Association, Columbus, Ohio, May 28, 1918.

"A house divided against itself cannot stand," you know, and it certainly seems as if we were building up with one hand and depleting with the other, when we advocate the highest and best possible training opportunities for young women, better and bigger schools, and more far-reaching service, and at the same time maintain the multitude of small schools which even now have difficulty in getting probationers. How much more difficulty there will be when other schools, directly or indirectly connected with military nursing requirements are established!

The small hospital is quite as important in its way as the large, and it has its own serious problems to be solved, chief of which is the nurse training proposition. Now to bring together my subject and the situation, as just presented, in the large and small training schools:—can we not establish schools for trained attendants connected with the small general hospitals (fifteen to fifty beds) which will do much toward solving many of the problems we have before us? These problems we must meet soon, or the result of a dearth of nurses will be tragic. First and foremost, these schools must not be in any way identified or connected with regular training schools for nurses. They should be established as schools for trained attendants only, with a certificate—not a diploma—given at the end of the prescribed course. If the hospital with which the attendant school is connected is known and advertised as *not* maintaining a regular training school, the attendants cannot pretend to be graduate nurses of that hospital. If we must have practical nurses—and we surely must—will it not be infinitely better to give them hospital experience under proper supervision than to allow the present example of practical nurses to do infinite harm through the very "experience" they rely upon? I am sure there are many of us who in our hospital life have seen sad examples of what the untrained practical nurse can do, particularly in obstetrics.

It is not necessary for the trained attendant to have any particular educational standards nor is there any special age limit. A grammar school education is usually sufficient, and the age must be left to the discretion of the superintendent. This gives a chance for a good and useful occupation for women who have been denied educational advantages or who are too young or too old to enter regular training schools, or who must be entirely self-supporting during the period of training. The available material for this work is very large, and it seems unwise, as well as unfair, to deprive so many of the privilege of ministering to the sick as we do under present restrictions. If all the small hospitals would open schools for trained attendants, think how many of these women understanding ethics somewhat would be prepared in one year's time to meet the increased demand for those who can care for the sick and wounded and supplement the graduate nurse in her work here and abroad.

Perhaps an outline of the course of a small school for trained attendants, such as that connected with the Middletown Hospital, may be of benefit. The course is twelve months with thorough instruction and practice in all branches in the practical work of nursing, some theory relating to this, and an equally complete instruction in dietetics and invalid cookery. It is interesting to note that we started this course in October, and in the November number of the *American Journal of Nursing* this subject was treated fully in a letter to the editor, embodying the ideas I already had in mind.

The attendants are at once put into the wards on a month's probation, and during that time they make beds, clean and dust wards and rooms, give cleansing baths,

etc. At the end of this period they are put into the uniform of the school—brown cambric, white bib apron, cuffs, and collar, but no cap—and for the next two months they are taught simple treatments such as enemas, douches and watching ether patients. After three months, they are instructed in taking temperatures, pulses, and respirations, administering medication—by mouth and hypodermically—giving temperature baths, sterilizing dressing instruments, etc. They serve one or two months on night duty and one month with the dietitian who teaches them to make invalid delicacies and to prepare trays. They spend one month in the maternity wing attending deliveries, assisting the graduate nurse, and giving after-care under direct supervision. One month is spent with the social service nurse in her outdoor work, and the pupil attendants also serve a short time in the operating room, learning general operating room routine, how to handle instruments, etc., although never taking an active part in operations.

The attendants are required to do all the ordinary cleaning in the lavatories, wards, and rooms, and the fact that much of their after success depends on these homely labors is emphasized. They are thoroughly instructed in disinfection, fumigation, and the theory of the care of contagious diseases, as the hospital does not take these cases except those usually found in general wards, such as typhoid or pneumonia.

At the end of the course the attendant receives a certificate, signed by the hospital authorities, stating that she has passed satisfactorily this period of instruction and is qualified as a trained attendant for convalescent nursing, emergency work and first aid, and has an understanding of invalid cookery. This certificate can in no wise be mistaken for a diploma, nor can the holder pass for a graduate nurse by displaying it, for the word "nurse" is not used, but "trained attendant" is especially designated, and her work stated to be that of a convalescent attendant with qualifications for emergency or first-aid work.

The wards and floors are in charge of graduate nurses who closely supervise the work of the attendant, and this is a fine field for the older nurse whose strength is limited, but who can do managing rather than the actual hospital nursing. Those who are unable to serve their country either at home or abroad, for the reasons above mentioned, can be an infinite help in this way and so do their share to relieve present conditions.

For compensation, we give pupil attendants \$10 a month for the first six months and \$15 to \$20 a month for the following six months. These prices may be modified to suit situations and conditions, but we must pay our attendants a higher salary than we would pupil nurses, as we are giving them less in theory and practice. The hospital furnishes board, room, and laundry, and the privileges of the home are the same as for pupil nurses.

The salary of the trained attendant, after she has completed her course and takes outside cases, should be from \$10 to \$15 a week, until her experience entitles her to more—\$18 or \$20. This cannot be strictly regulated, of course, but doctors and others who would be responsible in standardizing this approved schedule of prices, hospitals and registries, can be informed of these rates by the hospital with which the school is connected.

By the demand for practical nurses in Middletown, since I have been here, I am convinced that there is a large opportunity for women who desire this branch of the work, and, to me, it is a privilege to train them properly to meet this demand.



A Great Vision and Its Realization

To the Editor of THE MODERN HOSPITAL:

I have just returned from Creston, Iowa, where I spent ten days with Dr. F. E. Sampson in promoting the greater community association, of which he is the originator.

For thirteen years I have been director of the department on tuberculosis of this state, spending much of my time in lecturing on the prevention and control of this disease. I have been intimately identified with Dr. Sampson for the past ten years and am familiar with the greater community plan. Do not misunderstand me, however, for to Dr. Sampson belongs the full credit of the development of the scheme by which rural hospitalization may be assured. He has developed a modern hospital of considerable proportion, with a training school for nurses, standardized so far as the limits of his field would permit.

It is therefore a great opportunity for me to comment in a general way on the proposed plan and the hearty spirit with which it was met in the recent discussion, which I made throughout the area involved. There are five counties, Union, Ringgold, Adams, Taylor, and Adair, with large segments of other counties adjoining, embracing a population of 101,040 people.

A distinctive feature of the plan is that it makes organization coextensive with the territory involved and the hospital the social service center from which is correlated and sustained an educational program. It does not seek to develop new local organizations, but to coordinate the social, religious, moral, educational, economic, and medical forces.

It affords the opportunity for high standards of medical and surgical efficiency through the provision by the greater community of facilities for accurate diagnosis, including scientific laboratory methods, with a highly trained staff of specialists to cooperate with physicians and surgeons and the people of the respective communities. The hospital is not maintained in the interest of doctors, but for the conservation of health and life.

The relation which the medical profession sustains to the hospital is one of service, the regulations and requirements governing such service to be formulated by the greater community association itself. It is an attempt to bring the organized Christian and social spirit of each community into participation, for the promotion of preventive medicine. It is proposed to make the hospital the center, out from which four primary principles will operate:

1. To employ a social service secretary who will stimulate the instincts in each group to much greater participation, with emphasis upon child welfare as the first consideration.

2. To carry on a permanent educational program on preventive medicine, reacting upon each community, which involves country nursing and health supervision of the children of the various communities.

3. To provide a training school for nurses, second to none in the United States.

4. To establish a modern hospital in every sense under the control and supervision of the greater community association, which will provide for the hospitalization of all persons in need of such care.

In the interests of this greater community plan the board of trustees of Cottage Hospital has passed a resolution that as soon as such greater association is formed and in a position so to do, Cottage Hospital shall be made a free gift as the home from which this service may be rendered.

The scarlet thread running through this whole plan is that it provides for the play of human activities which are inspired by sympathy for the unfortunate and the poor without putting the tag of "charity" on the enterprise. It aims to restore the sufferer to his normal place in the community by giving him a man's chance.

Any person maintained by a social service committee, or church, club, public board or individual enters the hospital and receives such medical or surgical service as may be necessary, "without money and without price." All that any social service committee or other agent maintaining such individual, will have to pay, is such daily rate at the hospital as is necessary for his board, etc.

The free medical service is compensatory in that it is the contribution which the physicians make as their share of the community responsibility. That is, the community provides the hospital equipment, where the physician may develop the highest efficiency in serving, and when a patient receives outside aid, in whole or in part, then the attending physician or staff of the hospital must render services of the highest character free.

"Service" is the motto of the greater community association. It is a step forward in socializing medicine. It is now determined that no one man is big enough to cover the whole field of medical and surgical procedure without the assistance and cooperation of others, no matter what his attainments may be. The conclusion is that if a community will have service, then it must provide that organization and equipment necessary to such service.

It is one of the most attractive propositions which I have ever become interested in. It is a challenge to the church as a permanent organization looking for the highest welfare of humanity. It expresses its beneficent influence into the field of preventive medicine by the conservation of health and life and morals of the community. It would seem that a great prophet has arisen in Iowa.

ARETAS E. KEPFORD,

State Lecturer, Department of Tuberculosis, Des Moines, Iowa.

Mrs. Peggy Ann Sutton and Her Quilt

To the Editor of THE MODERN HOSPITAL:

At the meeting of the American Medico-Psychological Association in June at Chicago, I had as an exhibit a quilt which was made by one of the patients at this hospital, and which attracted a great deal of attention.

One of your representatives there asked me to send a picture of it to THE MODERN HOSPITAL. You will find enclosed a photograph of the patient, Mrs. Margaret Ann Sutton, aged sixty-four, admitted to this hospital November 1, 1907. She is of the depressed type of manic depressive insanity. This quilt was made of ravelings and thread picked up around the hospital. She does it without any drawing or any sample to go by. To illustrate: If any one goes through the hospital she will look at him and try to work his image on the quilt. She does it by hand, making one stitch at a time, unaided by any-



Mrs. Peggy Ann Sutton and her quilt. Mrs. Sutton, aged 64 years, a patient at the Central Hospital for the Insane, Nashville, Tenn., worked the quilt with her own hands, one stitch at a time, introducing in it portraits of the people whom she had met.

thing except her eyes and her tact in this line. Standing by her is a picture of the quilt that she has worked in this way. It is a novelty, and those who saw the quilt at Chicago said they had never seen anything like it before. The quilt is large enough to cover an ordinary bed.

We are trying to get all patients interested as soon as their health will permit. We have fifty ladies at work in the sewing room, tacking carpet rags, weaving carpets, and making dresses, shirts, etc., for the inmates of the

hospital, and we have recently made 200 new quilts. We manufacture our quilts in the old-fashioned way, using quilting frames, and about eight ladies can work on a quilt at one time. Many of our patients work on the farm, in the laundry, in the kitchen, help the carpenters—in fact, we have a six-hundred-acre farm in connection with the institution, and most of the work is done by patients.

W. S. FARMER, M.D.,

Superintendent, Central Hospital for Insane, Nashville, Tenn.

The Nursing Problem: Third-Year Training Under Government Supervision

To the Editor of THE MODERN HOSPITAL:

After reading in THE MODERN HOSPITAL several interesting articles relative to the urgent need of an increased and efficient nursing force, wherewith to care for the sick and wounded of our army and navy, the following plan suggested itself as practically covering the more pressing needs of the army and navy hospital service, while at the same time allowing a sufficient margin of supply to meet all urgent domestic needs.

In the first place, we would suggest that after suitable examination, senior pupil nurses be granted a certificate of proficiency—not a diploma—upon which they should be entitled to apply for admission to the United States Hospital service. Such advanced pupil nurses could render effective service in the wards, while, at the same time, they might receive special instruction under the direct supervision of United States Army and Naval Medical officials. By this means, immediate and effective relief could be secured, for, beyond doubt, many advanced pupil nurses would promptly and enthusiastically volunteer.

In the next place, provision should be made so that after one year's satisfactory service, each pupil nurse shall receive a government certificate of approval, which certificate, coupled with that of the school to which she is attached, shall assure to her the diploma of the school, the same as though she had completed the full term of three years under its immediate supervision and tutelage.

By this means the government would promptly secure efficient and urgently needed help, and the nurses would not be retarded in their life work, or in the opportunity to render early service in the cause which they hold so dear. Surely the year of intensive training through which such nurses would pass must more than equal the training of the best of our schools during equal time, and no truly patriotic school board could hesitate to carry such plan into effect during the period of the war.

Many training schools today find it advantageous to affiliate with others having special facilities for practical work in given departments of nursing. By such means, the general course may be appreciably broadened, and a more comprehensive education in the art of nursing afforded. Again, such a course has the effect of broadening and elevating the ethical standard, as well as the technical training of the nurse, and counts for betterment along all lines.

May we not hope that some such plan may be adopted and speedily carried into effect, thus obviating further delay at this critical time? Relief through the release of a large corps of sufficiently trained nurses would be immediately effected, while, in addition, opportunity would be afforded our schools to accommodate a much larger number of junior pupils who speedily could be rendered efficient in the care of the less serious cases coming into the wards of our home hospitals.

AUG. KÖRNDORFER, M.D.,

Medical Director, Children's Homeopathic Hospital, Philadelphia.

The Institutional Farm, Garden, and Dairy Consultant

To the Editor of THE MODERN HOSPITAL:

One of the things provided for in the administrative code bill of Gov. Lowden's was the appointment of a farm, garden, and dairy consultant for the institution farms in Illinois. Upon recommendation of the Department of Agriculture, I was appointed by Charles H. Thorne, Director of Public Welfare, to fill this position. The instructions covering my appointment directed me to "ascertain the acreage connected with the different insti-

tutions, make a study of the soil conditions at the different places, make recommendations, and prepare a system of farm accounting applicable to all."

Shortly after my appointment I issued a call for a meeting of the head farmers, gardeners and dairymen to be held at Springfield on Feb. 14, 1918. They were instructed to bring with them, to this meeting, a plat of the different farms, showing the crops they were devoted to last year. The program included papers on "Maintaining the Fertility of the Soil," by Henry H. Parke, assistant director of agriculture; "A Business Man's View of the Farm, Garden, and Dairy of an Institution," by Charles H. Thorne, director of public welfare; and discussions on dairying, poultry, hogs, alfalfa as an institution crop, truck gardening, manure pits, corn-planting, etc.

This proved to be a very interesting and instructive meeting, and I am satisfied that it has been a great stimulus to increased production and improvement of soil conditions at all of the institutions, besides providing me with plats of the different institution farms, and the ground devoted to different crops last year. From that information I could form an idea of what the crop outlay for the present year should be. The total area of the land owned by the state at the different institutions has been found to be 11,178 acres, and is divided among the different institutions as follows: Alton State Hospital, 1,034 acres; Anna State Hospital, 559 acres; Dixon State Colony, 1,100 acres; Chicago State Hospital, 238 acres; Soldiers Orphans' Home, 94 acres; Illinois State Reformatory, 276 acres; Elgin State Hospital, 510 acres; School for the Deaf, 159 acres; School for the Blind, 40 acres; Illinois State Penitentiary, 2,360 acres; Jacksonville State Hospital, 343 acres; Kankakee State Hospital, 950 acres; Lincoln State School and Colony, 528 acres; Peoria State Hospital, 520 acres; Soldiers' and Sailors' Home, 178 acres; Training School for Girls, 240 acres; St. Charles School for Boys, 917 acres; Southern Illinois Penitentiary, 524 acres; Watertown State Hospital, 593 acres; Soldiers' Widows Home, 15 acres.

The land connected with these institutions is made up of many different kinds of soil, and the climate varies as much as 11 degrees in mean temperature between the extreme northern and southern institutions.

The general policies I expect to carry out at the different institutions may be summarized as follows:

1. To maintain and increase the fertility of the different farms. This can be done at most of the institutions by the use of the stable manure, crop rotation, and the raising of legumes, but at some of the larger farms it will be necessary to buy lime, phosphate and kainit.

2. To utilize the inmate labor to the largest possible extent, so that they can be made as nearly self-supporting as possible. This is not only a source of profit to the state, but a benefit to the inmates themselves.

3. To adapt the different institutions to the needs of all; in other words, where the climate and land are specially adapted to a certain crop, to raise enough at that institution to supply the needs of some other institution where that crop cannot be successfully grown. We expect by following this policy to be able eventually to raise nearly everything in the farm and garden line used by the different institutions. Where a surplus of supplies or equipment is found at any institution, it is transferred to some other place where it can be used. This saves a great deal of buying, and also prevents actual waste in a good many instances. We are also able to introduce new blood into our hogs, poultry, and cattle in this way without paying fancy prices to outside parties. I venture to

say that the amount of institution transfers will amount to fifty thousand dollars by the end of this year. At this time we have available for transfer twenty tons of alfalfa hay and eighty tons of mixed hay.

4. To keep at least sufficient hogs at all of the institutions to consume the swill at each place. The records at one institution indicate a profit of over fifty dollars a day, and at another of ten thousand dollars a year over what the swill was formerly being sold for.

5. To build up and ration properly the dairy herds for greater milk production. To this end I am discouraging the use of prepared feeds, but recommending corn silage, alfalfa, clover hay, ground corn and oats, bran, and a small amount of cotton seed or oil meal. To increase the value of the silage, soy beans and cow peas have been sown with part of the corn at all of the institutions. This not only will increase the amount and value of the silage, but is also good for the ground.

As an example of what this position will eventually mean to the state, I am going to cite two instances. On my first visit to one institution about five or six hogs were just getting over the cholera. When I asked what was being done with the swill, I was informed it was being given away and that hogs could not be raised there successfully on account of cholera. On my recommendation one hundred and twenty immune hogs were purchased for this institution and eight immune sows transferred there from another institution. On my last visit I found all these hogs were being maintained on the swill that was formerly given away, and the net profit was easily fifty dollars a day. None of these hogs have died, although this was over three months ago.

At another institution in which the dairy herd was entered in a cow-testing association, I asked the department for the privilege of buying just what was needed in the way of a dairy ration, with an idea of following this proceeding at all of the institutions if the result obtained indicated it would pay. The daily profit on this herd, as shown by the report of the Jacksonville-Whitehall Cow-testing Association, has been as follows: January, \$6.00; February, \$9.73; March, \$14.00; April, \$16.33; May, \$24.29. Average number of cows in milk, thirty-four. Time of starting rationing, latter part of January. If the profits can be increased to this extent on thirty-four cows owned by the state, under this department, it can readily be seen what it will amount to on the whole fifteen hundred cows. We expect to follow this arrangement at all of the institutions now.

It is the desire of Governor Lowden that the farm and garden activities compare favorably with the best of these industries in private hands, and it is my policy to try to carry out this desire, and at the same time to conduct these activities in such a way that they will be a profit to the state.

CHARLES T. HOBLIT.

Farm, Garden and Dairy Consultant, Department of Public Welfare, Springfield Ill.

Friendly Relations with Patients Established at Admitting Desk

To the Editor of THE MODERN HOSPITAL:

Following the publication of an article in the April number of THE MODERN HOSPITAL on "The Admitting System in Use at the Milwaukee Children's Hospital," we received some inquiries concerning the attitude of patients toward the rather comprehensive questioning that is necessary for filling out our registration card. After a year and a half of this admitting system, we were quite firmly convinced that there was no resentment on the

part of patients. However, in order to have a basis in fact for our reply to these inquiries we made a survey of all one-visit cases for a month, presuming that in this group we should find resentment if it existed anywhere.

The survey was begun June 15 and covered all the one-visit cases for April, 1918, a month during which, owing to a temporary shortage of workers in the social service department, no purely medical follow-up work was done.

We found that there were 49 one-visit cases for April. In 29 of these, return was unnecessary and no return dates were given. (Eight had been transferred to the wards or to other medical institutions; 16 had negative findings or had necessary work completed in one visit; one came from a family physician for consultation only; 4 were referred to private physicians as ineligible for dispensary care.) In 3 other cases we knew that the reason for non-return had no connection with registration because other children in the same families were being brought to our clinics.

There remained, therefore, 17 children, the reasons for whose non-return were in question. A member of the social service department visited the parents of these patients. In all but one case, which could not be located, a thorough investigation was made to get the real reasons for non-return. *In not one of these cases was the reason for non-return in any way suggestive of resentment at the questioning that was done at the registration desk.* The reasons obtained were as follows:

Well—no need for return.....	5
Mother working—no one to bring child.....	2
Mother confined—no one to bring child.....	2
Family moved out of city before date for return (information obtained from relatives).....	2
Home broken up—child in county institution.....	2
Child on summer outing—went before date for return to clinic	1
Mother afraid of x-ray.....	1
Child afraid of dentist.....	1
Family quarantined with scarlet fever.....	1

This study has strengthened our belief not only that no resentment results from the registration interview but that a feeling of friendliness between the hospital and the patient is established at the registration desk.

HARRIET GAGE,

Director of the Social Service Department of the Milwaukee Children's Hospital.

The Health Officer and the Big Fight

Which health officer should stay at home and who should go to war? How is the nation bearing up under the war-strain? What are the special war-time health menaces of the civil population, and what are we going to do about them? What headway are we making against the venereal diseases? These are the questions to be considered at the convention of United States and Canadian sanitarians at Chicago, October 14-17, to be held under the auspices of the American Public Health Association. Some of the military sanitarians who will address the meetings are Surgeon General Gorgas, Colonel Victor C. Vaughan, and Major William H. Welch of the Army Medical Corps. Other speakers at the general sessions will be George H. Vincent, President of the Rockefeller Foundation; Dr. Charles J. Hastings, President of the American Public Health Association; Dr. W. A. Evans, Assistant Surgeon General Allan J. McLaughlin, U.S.P.H.S., Dr. Ernest S. Bishop, Dr. Lee K. Frankel, Dr. Frederick L. Hoffman and others.

The final program will appear in the *American Journal of Public Health*, appearing September 25. For further information write to A. W. Hedrick, secretary, American Public Health Association, 1041 Boylston St., Boston.



Conducted by ANNIE W. GOODRICH, Principal Army School of Nursing and CAROLYN E. GRAY, Principal City Hospital School of Nursing, Blackwell's Island, New York.

Please address items of news and inquiries regarding Department of Nursing to CAROLYN E. GRAY, Principal City Hospital School of Nursing, Blackwells Island, New York.

VASSAR'S RESPONSE TO THE NATION'S NEED FOR NURSES

Serious Motives of Candidates for Nurse Training at Vassar "Plattsburg"—Evidence of Practical Fore- sight in Plans for Course

By CAROLYN E. GRAY, R.N., Principal, City Hospital School of Nursing, Blackwell's Island, New York City

Four hundred and thirty-seven women, graduates of one hundred and seventeen different colleges, representing forty-six states and two English colonies, assembled at Vassar College, pursuing an intensive preparatory nursing course, constitute the concrete and very practical form which this response has taken. We have heard much of the need for nurses. Our government has called for them in ever-increasing numbers. Many and widely differing schemes have been proposed in all seriousness as the only way to staff our civilian hospitals and release our trained women for government service. In this very real difficulty the nursing profession has argued that standards should not be lowered, that the best our nursing schools have been able to produce were none too good for our country's need. We have been encouraged by the whole-hearted support of educators, who appreciate the many-sidedness of our problems, and whose position probably enables them to obtain a better perspective than that of the harassed superintendent of a nursing school whose own immediate problems are so pressing and urgent that she "cannot see the forest for the trees."

Nursing is peculiarly a woman's problem, and it is thrilling to think that the idea of the training camp at Vassar originated in the mind of a woman, Mrs. John Wood Blodgett. The plan has had the whole-hearted support of the college trustees and the Vassar faculty, who have thereby shown how able and ready they are to live up to the best traditions of Vassar, and that they stand for such education of women as will fit them for the tasks and responsibilities awaiting them. The curriculum of the Vassar Training Camp is no "idle dream." It is the work of a committee appointed by the National League of Nursing Education, and represents a three months' course of intensive study in the sciences, biology, chemistry, nutrition, etc., that underlie nursing. If the impressions of an afternoon's visit to several classrooms count for anything, it is no dilettante undertaking, and the young women who persevere will have proved their right to careful consideration by the various nursing schools which they elect. Some of us have feared that the nursing motive might not be sufficiently stressed and

that possibly too much emphasis might be placed on the sciences. These fears were dispelled by a visit to the classrooms where "practical nursing procedures" are taught. The large rooms of a gymnasium building, equipped with the usual hospital furniture, make very practical and workmanlike wards, and groups of students were busily employed at bed-making, bathing, and the usual tasks that fall to the probationer and junior nurses. The atmosphere of these classrooms was very earnest and sincere and the interest was quite as great as in the other laboratories.

Another point of special and practical interest is the fact that students who have a tendency to "flat-foot" have corrective exercises prescribed which are practiced under the direction of a teacher of physical education. This means so much to the prospective nurse and the school to which she goes that one feels specially indebted to the broad-mindedness of those who sought and obtained the advice of training school superintendents.

Among other evidences of practical foresight is the fact that the rising hour is identical with the popular (or unpopular) hour in our schools.

"It's ten to six, my room-mate!

Oh, say five-fifty instead!

It gives an earlier impression,

Of what time we get out of bed."

One can anticipate the gratitude with which probation instructors will welcome groups of pupils who have formed the habit of rising at 5:50 a. m. This early rising hour gives time for "setting up" exercises which are conducted, unceremoniously, in the corridors of the various buildings; the students being allowed to appear in pajamas, bloomers, etc. That no time is lost is shown by the fact that breakfast comes at 7 a. m. and the first classes assemble at 7:50.

The following story suggests that humble duties are not neglected.

"Wakening in the middle of the night, one of Company A's in-dustrious maidens rose from her bed, got her duster, dampened it in correct style, and began to dust—when her room-mate awakened her enough to convince her that inspection seldom or never occurs at 2 a. m.—and the dust and the maiden settled down once more."

Moreover, it was good to see such a wholesome-looking group of enthusiasts in the probation uniforms of their respective schools, and the blue, gray, brown, pink, and stripes never showed to better advantage than on the campus of Vassar. One interpreted it as an evidence of closer cooperation between colleges and nursing schools and earnestly hoped that it was only a beginning from which much of mutual benefit might develop. The nursing profession is expecting great things from this group of picked women, many of whom in addition to their college training have had valuable years of experience, for it is encouraging to note that over two hundred have been teachers. That these women appreciate their responsibility and opportunity cannot be better told than by one of their members:

"Three weeks ago, we came, four hundred and thirty-seven strong, with our eager faces turned toward France. We thought of Vassar gaily as a 'wait between trains,' and even regarded our hospital training as an inconvenient, though necessary, interruption in our progress toward the western front. Three weeks, so short when measured against the long months of the Great War—short even when compared to the one hundred and twelve

¹The stories quoted are taken from the *Thermometer*, published weekly by the Form Unit and the Nurses in Training at Vassar College.

weeks of training which lie before us, but how long in the vistas of opportunity which they have opened up.'

"Already, we have found, beyond the immediate, pressing need of our soldier boys, an infinite human ache which we are longing to heal. It is not that we care less for our boys. Each day brings a clearer realization of the value of their splendid youth and strength, but these three short weeks have brought to us the greater vision, the vision of all who suffer and to whom we may bring relief. When our blundering, awkward fingers have grown deft and skillful, we shall find our place. Over here or over there? It does not matter, and this is the wonderful lesson which Vassar has taught. In the lecture, in the classroom, in the very atmosphere of the camp, there has come to us this message. Service is greater than war, or peace, greater even than death. It is the very soul of life. We are talking less of France these days. Most of us realize that ours may be the sacrifice of 'those who stay at home,' but because of these wonderful weeks we are ready to serve either over here or over there."

Some one has said that in this whole scheme, the college woman is on trial; perhaps she is, but it may be well to remember that the training schools are also on trial; and most of all, those who are responsible for the conditions (whether good or bad), in our schools and the hospitals which they serve.

THE AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS

Purposes of the New Organization—A Directory of Social Service Departments to Be Ready at Next Meeting

For several years the annual meeting of the National Conference of Social Work has been the occasion for the gathering of a group of hospital social workers from all parts of the country for the discussion of their common problems and interests. Among the group there has been a growing idea that they should sometime form a national organization. This idea found concrete expression at this year's national conference at Kansas City, Mo., in the organization of the American Association of Hospital Social Workers.

The very circumstances which make it difficult to form a new association this year make it also urgently desirable. The ranks of hospital social workers are much broken, since many of their most experienced workers have gone into Red Cross or other war service of one kind or another. Hospital social workers are facing the necessity of using more volunteer service, of training new workers, and of meeting new demands with decreased resources. Therefore, although they can ill spare time for a new form of activity, they can still less afford to go on without some concerted means of maintaining the quality of a work assuredly more necessary to the country's welfare now than ever before.

The purpose of the new association, as stated in its constitution, is "to serve as an organ of intercommunication among hospital social workers, to maintain and improve standards of social work in hospitals and dispensaries, and to stimulate its intensive and extensive development." All individuals and institutions in the United States and Canada that are doing social work in hospitals and dispensaries, and those who are "contributing to the development and execution" of such work are eligible to membership. Active members are to be those who are actually doing the work; those who contribute to its development are to form the associate membership.

The officers are: Miss Edna G. Henry, director of the

social service department of the Robert W. Long Hospital, University of Indiana; vice-presidents, Miss Ida M. Cannon of the Massachusetts General Hospital, Boston, and Miss Mary E. Wadley, of Bellevue Hospital, New York City; secretary, Miss Mary Antoinette Cannon, of the University Hospital, Philadelphia; treasurer, Miss Margaret Borgden, of Johns Hopkins Hospital, Baltimore; executive committee, Miss Marion Prentiss, of Cook County Hospital, Chicago; Miss Marion Tebbets, of Elliott Memorial Hospital, University of Minnesota, Minneapolis; Miss Ethel Riddle, of Barnes Hospital and Washington University, St. Louis; Miss Harriet Gage, of the Children's Hospital, Milwaukee; Dr. Louis Morrow, of the University of California; Miss Mary H. Coombs, of the New York Conference; Miss Mary Jarrett, of the Boston Psychopathic Hospital; Miss Margarita Ryther, of the Protestant Episcopal General Hospital; and Miss Grace Bolen, of the Post-Graduate Hospital and the New York School of Philanthropy; and Mrs. Roberts, of the Philadelphia General Hospital.

The association is to hold its annual meeting regularly at the time and place of the National Conference of Social Work and will also hold meetings with other conferences of associations with allied interests. The next meeting will be held at Atlantic City in September, at the time of the annual meeting of the American Hospital Association. The Association of Hospital Social Workers expects to have a newly compiled directory of social service departments ready for distribution at that time, and also some literature on various special phases of the work.

The subjects already suggested for consideration by the association are of wide importance and reach to the foundations of our work. Training for hospital social work is one such elemental problem. There is at present no uniform course of training which can be required or recommended; hospital social workers have thus far been made by the most varied combinations of experience. There are, however, several different courses in operation, and it should not be impossible to standardize these and then to require them for workers entering the field.

The definition of the function of hospital social work is a subject closely allied with that of training, and one which must be worked out in connection with other specialized social agencies, and with the group of hospital administrators and physicians. With a more exact understanding of their proper field and use should come better and more nearly uniform records, statistics, reports, and methods of case-work.

All this and more will be the concern of the association. It is essential to its success that it have the active support of those interested in hospital work throughout the country. Membership application blanks may be had from Miss Ida M. Cannon, the Massachusetts General Hospital, Boston, and the association most heartily urges all concerned to join.

That only which we have within can we see without. If we meet no gods, it is because we harbor none. If there is grandeur in you, you will find it in porters and sweeps.—Emerson.

For everything we leave undone we must sooner or later pay the bill, and we should take this into account before we give our orders to Fate.—Ellen Thorneycroft Fowler.

Never bear more than one kind of trouble at a time. Some people bear three: all they have had, all they have now, and all they expect to have.—Edward Everett Hale.

SOCIAL SERVICE MADE A PART OF NURSES' TRAINING

Louisville City Hospital Social Service Department Proves a Success—Scope of Its Work

The social service department of the Louisville City Hospital, inaugurated with the approval of Mayor George Weissinger Smith and the Board of Public Safety, on December 1, under Miss Mary A. Alexander, has already proved its value to the hospital. The organization of this department of the hospital activities, the necessary printing of its blanks and forms and the working out of the details of its operation in connection with the curriculum of the training school for nurses has necessarily taken some time, but in spite of this, 101 investigations were made during December.

The course in social service work has been made a part of the curriculum of the training school for nurses, each senior nurse being assigned to this department in turn for six weeks' training in the field. Shortly the members of the junior class are to begin work under supervision in the large out-patient department, where from 150 to 225 patients a day are treated. In addition to the practical work which the individual nurses assigned to this department will obtain, they will, in assembled classes, have lectures and text-book study on the many aspects of social service activities.

The work of this department is expected to correlate the medical and surgical treatment with the social and economic side of the patients in the hospital and after they are discharged. Many a surgical patient has been discharged, greatly improved, into improper and unhygienic home surroundings, and subsequently returned for a more prolonged stay in the hospital.

The hospital is not a home for convalescents but a refuge for the sick, and by cutting down hospital days of patients, beds are made available for the acutely sick, provided they go into homes where convalescence and right living can be supervised. This is one of the chief functions of this department.

An investigation is made of all admissions; a social diagnosis is made, and no case is dismissed except through this department. Home conditions have first been investigated before the patient is discharged. Many patients have been admitted who are not residents of the city and not entitled to hospital care. These are properly investigated and made either county cases or sent to other institutions.

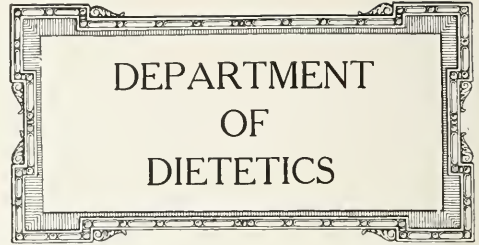
The work will be in the closest cooperation with all other social agencies, and the student workers will study closely all other institutions in the city, with which this cooperation will obtain so they may determine whether they will desire to take post graduate training in social service work after leaving the school.

The visiting staff member is requested to make specific recommendations on special blanks regarding social treatment of every patient he discharges, thus obtaining a close medical and surgical cooperation with the social side.

It is planned to have an advisory committee composed of a member of the board of safety, the superintendent of the hospital, the superintendent of the training school, one or two laymen, and two women specially interested in social work, with five members of the visiting medical and surgical staff, representing the various specialties.

It is believed this new department will soon demonstrate its value to the hospital and to the correlated charitable and social agencies of the city.

The motto of the hospital in all of its departments is SERVICE.



Conducted by LULU GRAVES.

Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, in care of The Modern Hospital, Garland Building, Chicago.

The meeting of the American Dietetic Association will be held in Atlantic City, September 26-8, at the Royal Palace Hotel, in conjunction with the American Hospital Association. Sessions of the American Dietetic Association will meet Thursday and Friday afternoon and Friday evening. The general session on Friday evening will be devoted to the interests of the American Dietetic Association; a business meeting will be held which will be announced later.

It will be noted that many phases of the work of a dietitian are being presented. That much benefit is derived from discussions is recognized, and the program is being arranged with the thought in mind of having ample time for discussion of each paper. Effort is being made to avoid crowding so much into the program that no time will be left for private conferences and for seeing the exhibits of food products and equipment. We shall want to hear some of the papers scheduled on other programs.

There has never before been offered such an opportunity for the accomplishment of a work which will be of value to our hospitals as at this meeting of superintendents and dietitians of hospitals and representatives of commercial products in which we are interested. Though the expenses of traveling have increased very materially during the past year, it is to be hoped that this will not interfere with the attendance at this meeting.

A tentative program is published in this issue of THE MODERN HOSPITAL in connection with the program of the American Hospital Association. We shall have a definite program ready for mailing early in September.

* * * *

FOOD CONSERVATION IN AN OHIO HOSPITAL*

How Miami Valley Hospital Hooverizes—Suitable Substitutes for Wheat, Sugar, and Fat—Some Appetizing Menus—Close Inspection of Diet Kitchens

By SARAH BENEDICT, Dietitian, Miami Valley Hospital, Dayton, Ohio

Each household, large or small, has had to meet and handle in a pioneer way the problem created by Mr. Hoover's request to conserve, that the Allies and our own soldiers may have food in order to do their work well. There has been no precedent for it in our generation. Many of us have felt that we would be glad to fulfill government requirements, if conditions were only a bit different; if there were not so many things to conserve at once; if only the problem did not loom so large and

*Read at the Fourth Annual Convention of the Ohio Hospital Association.

important when help was so very scarce, that it would be far easier in an ordinary household than in an institution, because there one could be quite sure that the members of the family would understand and help, while in a hospital, there are so many people who do not understand, and who attribute to you hard money-saving considerations which are far from true. But the task with its many and harassing difficulties still remains, and if we are to "stand with the colors behind the lines," we shall continue to meet the requests of the government to the best of our ability. I am not at all vain about what we have accomplished at the Miami Valley Hospital. Perhaps many of you brought your dietary scheme to a more satisfactory basis, both in ways of conforming to standards set by Mr. Hoover, and in your ability to give a moderately full and varied diet to your patients.

We have come some distance, however. Perhaps you would not have to admit, as I do, that in the days before the war, ends of loaves of bread, dried slices of bread and toast accumulated to such an extent that when the bread-dressing, bread-pudding methods of usage were exhausted a man who kept chickens had to be found to care for the rest. When the United States entered the war we used many methods to break up evil habits—even dreaming that we could accomplish something by talking to the maids in the various tray kitchens on the subject, and to the student nurses in charge. The results were a commentary on my ability to talk—humiliating in the extreme.

Our present method does bring results. My assistant now visits the tray kitchens three times each day—inspects bread-boxes, and makes the next delivery of bread from the kitchen in accordance with the findings. Incidentally, she makes observation of the number of oranges, lemons, eggs, and amount of broth in each ice-box. An overstock of all of these has been prevented, thus eliminating the usual waste.

This method, you will say, does not train the nurse, and I may make reply that, in ordinary times this might not be the best method, but while the war makes the conservation of food a paramount duty, it is the most effective way of accomplishing the desired result that we thus far have devised. The average nurse is one of the few people very much protected from the exigencies of the food situation. She neither markets nor is in contact with those who do; therefore she feels that the request to put the ends of loaves on the bread and butter plates of the public patients or not to cut crusts off toast is, to use her phrase, "carrying this economy racket pretty far."

Of course, our present method of lowering the output of bread does not entirely do away with the ends of loaves, the occasional slice cut in excess, or the few slices of toast prepared against a possible need. We continue to have enough dry bread to serve dressing with the occasional veal dinner. At these times we ask that small servings of bread be given, feeling confident that few people will care for even an ordinarily large portion of both. The glorified steam bread pudding, made up with ground bread crumbs and ordinary cooking figs, is a "joy forever" in using up left-over wheat bread. Other steamed puddings, while they seem a bit heavy for a hospital dietary, do splendid service in providing a nutritious dessert, with a bread crumb foundation, with suet for shortening and molasses for sweetening. The fact that custards and milk puddings of all kinds may be procured from the diet kitchen for the use of patients not able to partake of such heavy food makes this dietary measure a feasible one. We also have croutons in place of crackers, served with bean soup and cream soups. We

use many bread crumbs in muffin batter, with scalloped dishes, and as a crust or cover for oven-fried fish. Whenever we have pie on the menu for servants, we use rice flour or corn-meal with the wheat flour. At the nurses' house we conform to requirements in the way of wheatless days and wheatless meals. We did have a time to train our family to live on the prescribed one and one-half ounce of sugar a day. I am not able to say that we have absolutely conformed to that amount, but we have endeavored to do so. Our nurses could certainly make use of more of it, were it permitted them. A recent measure has been to do away with coffee for the mid-day meal, and substitute milk. Nurses are, for the most part, great coffee-drinkers, and ours felt that this change was a real hardship. The change is better for them, and removes the temptation to exceed the sugar limit.

We are using an abundance of corn syrup, both in the nurses' house and in the servants' dining room. We find the light-colored Karo a pleasant means of sweetening cocoa. And when a hospital has an abundance of milk, cocoa is an easy method of adding nutrition to a meatless supper. An occasional serving of cottage cheese has been acceptable. Ice-cream made from whole milk and enriched with custard made from the yolks of eggs constitutes an inexpensive but nutritious dessert for nearly every patient in the hospital. The yolks used are the ones which had been collected from the tray-kitchen ice boxes, having been left there by the nurses making orange or lemon albumins. If these are to fulfill their greatest usefulness, they must be brought to the kitchen every morning in time for use there, that they may thus be prevented from becoming stale or dry. When the hospital has many patients newly operated on, the by-products of egg albumins are sufficient to make our custards and salad dressings, besides being used in ice cream. While speaking of milk, I might add that we have done away with buying inferior buttermilk, and make a satisfactory product from buttermilk tablets and fresh whole milk.

While we have not had absolutely meatless days for the hospital patients, the quantity served has been considerably lessened, and for the normal part of the household, the nurses, the doctors, and the servants, we have continued to have meatless days, even though they are not required. The luncheon dishes of cheese, or eggs, or fish and a light salad with pie as a dessert (usually the one-crust kind) and either a cream soup or vegetable soup as a first course, has been a welcome variation from the meat and potato type of mid-day meal.

We have made it a point to use beef very much in excess of what we would ordinarily use, that the immature animals might not be sacrificed. By a little concentration on the subject we found that we can use a number of supper dishes which would have very little or no meat in them; a chowder made like turtle soup, but with more vegetables; baked rice; tomato and meat; spaghetti cooked in oxtail broth, and little bits of meat added; escalloped tomatoes; corn pudding; scrambled eggs with small bits of ham; peppers stuffed with rice or bread crumbs mixtures—all of these are favorites.

In regard to the conservation of fats, we have brought about no more valuable reform than that of persuading the chef to trim his meat carefully, making use of every available pound, and thus preventing the constant dipping into the lard-can on every occasion. We have lost a devoted friend by this policy. The fat-and-bone man with soap interests complains bitterly that there isn't any use making his horse climb the hill any more.

Butter-cutters which divide one pound into forty-eight

pieces have been of value in saving this form of fat. In the tray-kitchens we keep a little earthen-ware bowl, which is understood to be for our purpose—the collecting of bacon-fat and left-over butter. When this fat is brought to the kitchen and clarified, by means of careful heating, with a few slices of raw potato, it makes a most satisfactory frying medium; and our janitors and orderlies crave fried food.

In conclusion, I might say that a great deal of waste may be avoided if the original quantities, sent from the kitchen, are gauged with some degree of judgment. We have a small dipper which contains three portions of stewed or canned fruit or vegetables. The average chef needs, particularly if he is black, a great deal of observation, both as to the manner of carving and the quantities sent out. A frequent visit to the garbage-cans will reveal much, often, in waste of food, when one thinks all is well. It often reveals that some part of the house is failing to separate paper from garbage.

Careful marketing is, of course, a prime requisite in kitchen economy, and even that has a new phase to it in these recent months. No longer is it merely a question of reasonable price (there really "ain't no such thing") but also of "How much help will I be able to muster to prepare these vegetables."

* * * *

SOME OF THE LATEST BOOKS ON DIET AND NUTRITION

Interesting and Valuable to the Nurse, the Dietitian, and the Medical Man—Comprehensive Discussion of Diet in Health and Disease

The attention of the dietitian must soon be given to class work for the coming year. So many books and articles are being published on various phases of dietetics, and with varying degrees of authenticity, that it is a great satisfaction to have access to a few which are to be relied upon and which meet our needs.

In hospitals where the work in metabolism is being done by the combined efforts of the medical men and the dietitian, the work will be of such a nature that a library will be most desirable.

If either the medical man or the dietitian is working without help or cooperation a few good books are indispensable, and the hospital or nurses' training school should realize this. This department has always advocated the close cooperation of the dietitian and the medical man, and the need for this is no less at the present time.

The following books which have come into our hands will be found valuable in any of these circumstances:

"Nutrition and Clinical Dietetics," by Carter Howe, and Mason, discusses the dietetic treatment of disease, covering the theories and facts that have been generally proved and accepted. Not only the opinions of the authors, but, in instances in which there is a difference of opinion by men of standing, both views are given. The text is divided into four parts:

Part I treats of digestion, absorption, excretion, and energy requirement. In the comprehensive treatment of these topics is included a concise statement on basal metabolism, and as much as is at present known about vitamins. The chapters on digestion and absorption are very good.

Part II is a detailed account of the composition and nutritive value of the common food elements, giving much information on these points in a conveniently small amount of space.

Part III is a discussion of feeding in infancy and child-

hood, including breast feeding; feeding normal and abnormal children; artificial feeding; feeding the premature infant; feeding after the first year; feeding during acute illness and nutritional disturbances.

Part IV, which comprises nearly half of the entire volume, is devoted to the dietetic treatment of disease. One may well judge of the emphasis laid upon this part of the volume by the introductory statement: "The intelligent use of food in disease should become more and more a matter of interest, not only to the specialist but to the practitioner as well, and the time is far past when the conscientious physician can afford to turn over the diet regulation to the nurse, prompted by the patient's appetite or lack of it." The chapters that follow take up the adjustment of food to abnormal conditions of the circulatory organs, the nervous system, and in miscellaneous conditions, in addition to those of the digestive tract and ductless glands which are ordinarily considered.

In reading this book one feels convinced that one is getting reliable information and scientific facts presented in a manner which it is a pleasure to read.

Anyone who has been interested in nutrition the past few years has learned to put absolute dependence upon the things said and done by Dr. Graham Lusk of Cornell University. The fact that his "Science of Nutrition" has reached the third edition is but another proof that this book has a wide acceptance. It has been revised and many important facts of more recent findings have been added. As the name implies, the subject is treated from the standpoint of the scientist and takes up in detail the determination of the caloric value of food and the influence of ingestion of food upon metabolism. It is a valuable book in the laboratory because of the specific manner in which the methods and results of tests are given.

A discussion of the most important and most commonly known diseases of metabolism will be found in "What to Eat and Why," by G. Carroll Smith. Not only is the treatment outlined, but equal emphasis is laid upon *why* the prescribed food should be given. Much valuable information in regard to dietetics is given in a way that makes it very interesting reading and easily understood, even by one who has little knowledge of food composition or food values.

"Modern Dietetics," by Lulu Graves, is a book written primarily for the dietitian and the nurse. Chapter I is devoted to the management of the institution dietary department. The common food elements, their composition, cooking, and place in the diet, are discussed in the chapters following, up to chapter XII. Special problems in feeding the various groups of people, diet in disease, recipes for serving large numbers of people, and tables of food values are other subjects for discussion. A chapter is also devoted to the teaching of dietetics to nurses.

Books dealing more specifically with some particular branch of treatment or some special disease include:

Hill and Eckman's "Starvation (Allen) Treatment of Diabetes." Details of this treatment of diabetes are given with typical case histories. Complete diet lists and recipes are given. So great has been the demand for this complete description of a method of treatment which attracted almost universal attention that the third edition has been issued.

A treatise which covers all the points of the subject necessary for the average nurse to know is "Infant Feeding," by Clifford G. Grulee. This book does not go into the details of scientific matter so extensively as does Morse and Talbot's "Diseases of Nutrition and Infant Feeding," but it gives enough of the physiology and bacteriology of the alimentary canal, the diseases common to

this tract, and chapters on nutrition, to enable the nurse to give intelligent care to infants and young children.

The authors of "Diseases of Nutrition and Infant Feeding," John Lovett Morse and Fritz Talbot, are in the department of pediatrics at Harvard Medical School and are associated with the leading hospitals of Boston. The method of infant feeding taught in the Harvard Medical School is described, including breast feeding and artificial feeding, with all the principles involved in each. The chemistry and bacteriological tests of the various forms of milk and of proprietary foods is given together with their advantages and disadvantages. The detailed scientific treatment of diseases of nutrition as well as the digestion and metabolism of food make this a very good book for one who is specializing in the clinical and practical side of feeding.

"Feeding the Family," by Mary Swartz Rose, is a book written primarily for the housewife, but which is equally applicable to those who wish to feed the people in their care intelligently. The book is not at all technical, and contains scientific information and facts pertaining to food materials which form the basis of a good working knowledge of dietaries.

Nutrition and Clinical Dietetics. By Carter Howe and Mason. Cloth, pp. 646, \$5.50. Lea & Febiger, Philadelphia and New York.

The Science of Nutrition. By Graham Lusk. Third edition, cloth, pp. 641, \$4.50. W. B. Saunders Company, Philadelphia.

What to Eat and Why. By G. Carroll Smith, M.D., \$2.50. W. B. Saunders Company, Philadelphia.

Modern Dietetics. By Lulu Graves. Cloth, pp. 214, \$2. The Modern Hospital Publishing Company, St. Louis.

Starvation (Allen) Treatment of Diabetes. By Hill and Eckman. Cloth, pp. 134, \$1.25. W. M. Leonard, Boston.

Infant Feeding. By Clifford G. Grulee. Second edition. W. B. Saunders Company, Philadelphia.

Diseases of Nutrition and Infant Feeding. By John Lovett Morse, A.M., M.D., and Fritz Talbot, A.B., M.D., \$2.50. Macmillan Company, New York.

Feeding the Family. By Mary Swartz Rose, Ph.D., Department of Nutrition, Teachers' College, Columbia University. \$2. Macmillan Company, New York.

* * * *

News Notes of Dietitians

Miss Lulu Graves severed her connection with Lakeside Hospital early in the summer in order to have the time necessary to finish work which had accumulated during the year and to perfect plans for the meeting of the American Dietetic Association. For the past two months she has been doing this work in the office of THE MODERN HOSPITAL in Chicago and at the same time doing some things in the interest of the department of dietetics. Miss Bessie Brenton, who was Miss Graves' assistant, is now head dietitian at Lakeside.

Miss Maude Perry, formerly dietitian at Michael Reese Hospital, Chicago, sailed early in July for overseas duty with the Michael Reese Hospital unit. Miss Perry is well known for her work as a dietitian as well as through her writings. The little book, "Food for the Sick," which was put out a year ago, by Doctor Straus and Miss Perry, has had a wide circulation. Miss Perry's last book, "Dietetics for Nurses," came from the press shortly before she sailed.

Miss Louise Stevenson, who was Miss Perry's successor at Michael Reese early in the spring, has been called by the Red Cross for service at Camp Custer.

We are always glad to know of any changes made by hospitals in their dietary departments. The following young women, who are all college graduates and have had

hospital training as student dietitians, have recently taken up the work of dietitian in hospitals as indicated:

Miss Gertrude Weber, of University of Illinois, at Olney Sanitarium, Olney, Ill.

Miss Esther Shawaker, of Pratt, at Lewis-Gale Hospital, Roanoke, Va.

Miss Ruth Schreiber, of Iowa State College, at Evanston Hospital, Evanston, Ill.

Miss Esther Ackerson, of Illinois University, at Michael Reese Hospital, Chicago.

Again we urge that any dietitian who is not sure that her name is on our mailing list send her full name and address to the editor of this department. It is much to be desired that some information about your department and your work also be sent in. This request has been made in this department before, but we are not in as close touch with what is being done in many hospitals as we could wish.

The Lay of the Government Lady

BY E. C.

Anna Maria Sophia Jones

Was just a bundle of skin and bones—

The sort of woman you often meet

With knobby fingers and large flat feet—

Her hair was dragged behind in a bunch,

And she had dinner when you have lunch.

The Government Lady came to the door—

With printed leaflets—dozens and more.

She spoke to Maria firmly and long—

And all that Maria did was wrong.

She oughtn't to peel potatoes and boil them,

To peel potatoes was only to spoil them;

She oughtn't to waste the pods of the pea;

She oughtn't to stew and stew her tea;

She oughtn't to feed her baby on bread

Before it had ever a tooth in its head;

(Anna Sophia, mother of five,

Three were dead, but two were alive,

Always had given her baby bread

Before it had ever a tooth in its head);

She oughtn't to spend her money on drink,

She oughtn't to stuff up the drain of the sink;

She oughtn't to shut out air and light;

She oughtn't to close her window at night.

(Anna Maria Sophia Jones

Always fastened her window-click,

Air in a bedroom made her sick);

She oughtn't to buy herself ready-made clothes—

She oughtn't—she oughtn't—Oh, goodness knows.

Before the Government Lady had ended

Anna Sophia was highly offended.

Anna Maria Sophia Jones

Was just a bundle of skin and bones—

The sort of woman you often meet

With knobby fingers and large flat feet—

Her hair was dragged behind in a bunch,

And she had dinner when you have lunch.

But Anna Maria had spirit within her—

The spirit that makes a saint of a sinner—

When she saw what was right she went and did it,

And then, if need was, afterward hid it.

Anna Maria Sophia Jones

Asked in dull and colorless tones

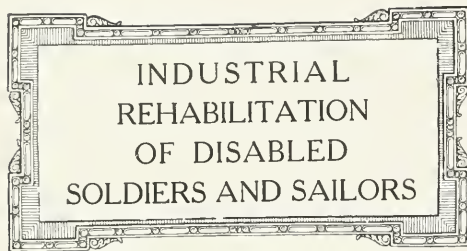
The Government Lady to walk inside,

Opened the door of the passage wide,

Took a chopper and hit her hard,

And buried the body in the yard.

—Exchange.



Conducted by ELIZABETH G. UPHAM.
Director Art Department Milwaukee-Donner College.

THE PERSONAL ELEMENT AND THE DISABLED SOLDIER

How Vocational Reeducation Strikes the Man Back From the Front—Disposing of Fears and Worries—Re-education Worth All It Costs

In the *Vocational Summary*, published monthly by the Federal Board of Vocational Education, Mrs. May H. Pope tells an interesting little story, which shows the attitude of the average returned soldier toward his own reconstruction for civil life again.

The story tells of the plans adopted by the Invalided Soldiers Commission of Canada as they appear to the individual soldier and thoroughly illustrates the importance of the personal contact of the men with the vocational officers and teachers and those who have charge of this work. The returned soldier in this story, an average Canadian, a carpenter by trade originally, was returned disabled by a mutilated shoulder which made him unfit for his former work. He wore the distinguished honor badge and had been known for conspicuous bravery even among the fighting Canadians, but was modest about it and considered himself just like any other returned soldier who had done his duty and earned the consideration of his government. The man was suffering, as those of his kind all suffer, from the shock of war, all the horrors he had passed through, all the worries about providing for the care of his wife and two children, and the fear that his vocational reeducation might deprive him of his just pension. Following is something of the story he tells in his own words:

"The journey across the continent had been long, and the clean hospital beds looked good to me. . . . The boys were doing all sorts of things, weaving baskets, embroidering, making cloth on a loom—queer work for soldiers, it seemed to me. One man was making a sweater for his little sister and another said his work helped him to forget his pains and aches. One day a sensible young woman came around with raffia in her hand and asked if I didn't want to make a basket. I refused at first, but to please her I began the basket. . . . Pretty soon I noticed that my fingers were limbering up considerably. That basket finished, I wanted to do something more difficult, and I did."

And again, "I didn't pay much attention to what the vocational officer said, for I thought the country owed me a living and I was satisfied with that. I am ashamed now that I harbored that thought for even a little bit, but a fellow who is just recovering from the awful strain of the life over there and not quite over his wounds can't be blamed too much. I had made up my mind to get some easy work, but after my talk with the vocational officer I no longer wanted to be a shirker. He made me see that thousands of my comrades in France were depending upon me and others like me for food and other necessities of life. He made me wish to be a man who counted for something in the industrial life of the country. We soon

got on friendly terms. I told him all about myself, for I felt I was talking to someone who cared.

"While waiting for my wound to heal, I joined some classes in the convalescent school and made several articles that now help to make my home attractive. When it came to choosing a real trade, I was rather hard-headed about it and wanted to go into one where my bad shoulder would have been too big a handicap. I was finally persuaded to choose one where my early training would do the most good; so I prepared to be a contractor. Then I began to be afraid that if I held down a job I would lose my pension and to worry about how my wife and boys could be cared for; but the officers assured me that pensions were given on the basis of physical disability and that an allowance would be sent to my wife each month while I was in training.

"They gave us good times, too—picture shows, sports, concerts and dances. The vocational officers are kind, but firm, too, and a man must stick to his work and not stay home unless he is really sick. If he does, he loses part of his pay. A man must make good. There will be plenty of help after the war, and employers are not to be expected to employ a returned soldier for charity's sake.

"Do I think the reeducation for the returned man does any good? Well, I guess I do. If it did nothing but show a fellow that there are some men in the world like the district vocational officer and the teacher, I would cast my vote for it. Nothing means more to a man who is 'down and out' than to feel that somebody understands. It puts heart into a fellow to be taught to help himself when he has lived for days with the dread that he might always be a burden to his family, and the knowledge that his country still counts on him to do his share makes him buck up as nothing else can. The men who are teaching these boys to live cheerfully in spite of their broken bodies are great. Yes, sir, it's worth all that reeducation has cost, just to show the returned man how to face life again."

* * * * *

THE INTER-ALLIED CONFERENCE ON AFTER-CARE OF DISABLED MEN

Healing of the Mind as Much a Part of Rehabilitation as Healing of the Body—Galsworthy's Foreword

The second annual meeting of the Inter-Allied Conference on the After-Care of Disabled Men was held in London, May 20-25, 1918. Delegates were sent to London from Belgium, France, Italy, Portugal, Serbia, Siam, United States, Canada, Australia, South Africa, New Zealand, India and Newfoundland.

The conference represented those most distinguished and experienced in reeducation in these countries. The purpose of the conferences has been stated by John Galsworthy, who has written the foreword to the published reports.

"The conference in Paris last year, and this conference in London, were summoned that the countries who stand shoulder to shoulder in the fight may stand shoulder to shoulder also in the task of remedy, profiting by each other's success, avoiding each other's failures; that the whole field of recovery may be surveyed; the holy purpose of this crusade of healing be fortified in the hearts of all who serve; and a sign made manifest to the peoples of each country that the debt due is remembered. To lift up the man who has been stricken on the battlefield, restore him to the utmost of health and agility, give him an adequate pension, and reequip him with an occupation suited to the forces left him—that is the process which does not cease till the sufferer fronts the future keen, hopeful and secure. And such restoration is at least as much a matter of spirit as of body. Consider what it means to fall suddenly out of full vigor into the dark certainty that you can never have full strength again, though you live on twenty, forty, sixty years. Though you have the soul of a hero, the flag of your courage may well be down half-mast."

The splendid idealism and the earnest purpose which inspired these workers and which pervaded the conference have been voiced by John Galsworthy in the following extracts from his Foreword:

"The Angel of Peace, watching the slow folding back of this darkness, will look on an earth of cripples. The field of the world is strewn with half-living men. That loveliness which is the creation of the esthetic human spirit—that flowering of directed energy which we know as civilization; that manifold and mutual service which we call progress—all stand mutilated and faltering.

"In every township and village of our countries stricken heroes of the war will dwell for the next half-century. The figure of Youth must go one-footed, one-armed, blind of an eye, lesioned and stunned, in the home where it once danced. The half of a generation can never step again into the sunlight of full health and the priceless freedom of unharmed limbs.

"France! The country of the long romance! Who can see France and not love her—the land with the mysterious smile, with the clear thoughts and the gay, unconquerable, self-seeing spirit? France, the eternal type of Mother-country—she surely will not fail her sons who serve and suffer. Italy, whom the gods love, and chose, I think, for the land where Beauty should be embalmed for ever, so that man might look on it age after age and drink of inspiration—she will not forget to fill again the lives of her wounded children with hopes and usefulness. And the Little Country, trodden and ravished—none in the world had quite her teeming energy—she will be last of all to let the stricken go down their days drained of strength and interest.

"America, too, I know, new as yet to this conflict and the wreckage thereof. Of this great, warm-hearted nation I prophesy deeds of restoration, most eager, most complete of all."

Of the disabled man, Galsworthy says:

"He shall yet live as happy and as useful—if not as active—a life as he ever lived before. Do your worst; you shall not crush him! We shall tend him from clearing station to his last hospital better than wounded soldier has ever yet been tended. In special hospitals, orthopedic, paraplegic, phthisic, neurasthenic, we shall give him back functional ability, solidity of nerve or lung. The flesh torn away, the lost sight, the broken ear-drum, the destroyed nerve, it is true we cannot give back; but we shall so re-create and fortify the rest of him that he shall leave the hospital ready for a new career. Then we shall teach him how to tread the road of it, so that he fits again into the national life, becomes once more a workman with pride in his work, a stake in the country, and the consciousness that, handicapped though he be, he runs the race level with his fellows, and is by that so much the better man than they.

"It seems, to one who has watched, rather from outside, that restoration worthy of that word will only come if the minds of all engaged in the sacred work are always fixed on this central truth: 'Body and spirit are inextricably conjoined; to heal the one without the other is impossible.' If a man's mind, courage and interest be enlisted in the cause of his own salvation, healing goes on apace, the sufferer is remade. If not, no mere surgical wonders, no careful nursing, will avail to make a man of him again. Therefore I would say: 'From the moment he enters the hospital, look after his mind and his will; give them food; nourish them in subtle ways, increase that nourishment as his strength increases. Give him interest in his future; light a star for him to fix his eyes on. So that, when he steps out of hospital, you shall not have to begin to train one who for months, perhaps years, has been living, mindless and will-less, the life of a half-dead creature.'

"That it needs special qualities and special effort quite other than the average range of hospital devotion, is obvious. But it saves time in the end, and without it success is more than doubtful. The crucial period is the time spent in hospital; use that period to re-create not only body, but mind and will-power, and all shall come out right; neglect to use it thus, and the heart of many a sufferer and many a would-be healer, will break from sheer discouragement.

"Of the men and women who have this work in hand I have seen enough—in France and in my own country, at least—to know their worth, and the selfless idealism which animates them. Their devotion, courage, tenacity, and technical ability are beyond question or praise. I would only fear that in the hard struggle they experience to carry each day's work to its end, to perfect their own particular jobs, all so important and so difficult, vision of

the whole fabric they are helping to raise must often be obscured. And I would venture to say: 'Only by looking upon each separate disabled soldier as the complete fabric can you possibly keep that vision before your eyes. Only by revivifying in each separate disabled soldier the will to live, can you save him from the fate of merely continuing to exist.'

* * * *

CARRY ON

A Magazine Devoted to the Reconstruction of Disabled Soldiers and Sailors

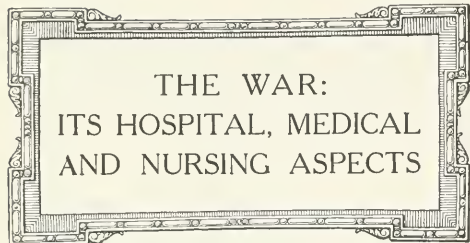
The office of the Surgeon General in Washington edits a little magazine called *Carry On*, which is devoted to reconstruction. It is published for the Surgeon General by the American Red Cross and was planned to give propaganda and education, not only to those interested in the work of reconstruction, but also, through them, to the general public, to prepare the public mind to regard the problems of the reconstruction of the disabled soldier in a sane and practical way and to prove to his family that he is not merely an object of sentiment and charity but a part of a great economic problem and an industrial factor in the country's welfare.

The editorial board includes Col. Frank Billings, M.C., N.A., director of the Division of Physical Reconstruction, Office of the Surgeon General, U. S. Army; Lt.-Col. Casey A. Wood, M.C., N.A., Office of the Surgeon General, U. S. Army, and Capt. Arthur H. Samuels, S.C., N.A., Office of the Surgeon General. The advisory board bears the names of ex-Presidents Roosevelt and Taft, Surgeons General Braisted and Blue, and many other well known men.

Some of the contributors to the August number include Mr. Roosevelt, Charles M. Schwab, director general of the Emergency Fleet Corporation, Judge Julian W. Mack, Augustus Thomas and John Galsworthy. It is needless to say that writers of international reputation are giving their writings to help in the reconstruction work.

The circulation of *Carry On* must necessarily be limited to those interested in the development of reconstruction work. Many thousands of requests have reached the Surgeon General and have been listed. Men and women who would like to receive this magazine and have not yet had an opportunity to subscribe, may do so by forwarding a request, and *Carry On* will be sent without charge for one year. Send name, address, and occupation to *Carry On*, Office of the Surgeon General, U. S. Army, 311 Fourth Avenue, New York City.

My dear Robert:—One passage in your Letter a little displeased me You say that "this world to you seems drained of all its sweets!" At first I had hoped you only meant to insinuate the high price of Sugar! but I am afraid you meant more. O Robert, I don't know what you call sweet. Honey and the honey-comb, roses and violets, are yet in the earth. The sun and moon yet reign in the Heaven, and the lesser lights keep up their pretty twinklings. Meats and drinks, sweet sights and sweet smells, a country walk, spring and autumn, follies and repentance, quarrels and reconciliations, have all a sweetness by turns. So good humor and good nature, friends at home that love you, and friends abroad that miss you—you possess all these things, and more innumerable; and these are all sweet things. You may extract honey from everything; do not go a-gathering after gall. . . . I assure you I find this world a very pretty place. —Charles Lamb to Robert Lloyd.



THE WAR: ITS HOSPITAL, MEDICAL AND NURSING ASPECTS

A V. A. D. IN A FRENCH HOSPITAL

Desperate Need for Nursing Care for the Wounded in Military Hospitals Over There—Letters of an English Volunteer

INTRODUCTION.

These extracts from a little volume entitled, "Letters from a French Hospital," are here republished by kind permission of Messrs. Houghton Mifflin & Co., because they give such a vivid picture of the need existing in the military hospitals on the other side. While these letters were written three years ago, the letter from the commander of an American base hospital in France, published in our editorial columns (August, page 115), indicates that the need for additional nursing care is not over. The fact that our own American boys may, by this time, be in need of the ministrations described makes these letters of renewed timely interest.—EDITORS.

EXTRACTS FROM "LETTERS FROM A FRENCH HOSPITAL"

Hôpital Temporaire, Somewhere in France, 31 July, 1915.

Of course, what I am doing is against my conviction. I think only fully trained nurses should help the wounded. But the fact remains that most fully trained nurses cannot afford to work for nothing, and support themselves, and unless V. A. D. people will come, the poor wounded are left to the orderlies. And I am, or any other outsider is, better than that. And oh, the poor, poor fellows lying in dirt and discomfort! I shall not write often while I am here because I can already see such piles of things that want doing. And there are not enough bandages, not enough dressings, not enough sheets and towels, not enough disinfectants, not enough anything. Thank goodness, I got accustomed to a certain amount of making shift at the Clinica. It was really a better training than an English hospital with everything tip-top. And Dr. ——— said I could feel assured that I knew enough to be a valuable help, and every batch of wounded will make me know more. Anyway, *animo v adelante*. . .

4 September, 1915.

. . . They are all so charming to me. As the wards are so big, it really is very little that I can do for each, and they make so much of it. They are not used to much care, and the little I give them is repaid a hundred-fold by their gratitude. Not one ever disputes a word I say; sometimes the orderlies fetch me because so-and-so won't do what he is told, and I wonder whatever I shall do if he does not listen to me, but I only have to appear and all is well. The other day I was fetched because a man operated on that morning would get up. He was a great big Breton, and I should have been nowhere if he chose to resist. When I got near, someone said, *Tiens, voilà Mlle. Mées!* Poor Févre looked round and said, *J'étais en train de me remettre, and got back as meek as a lamb.* As soon as they are up and convalescent, they try to help me with the cleaning, etc.

22 October, 1915.

Your nice letter just to hand. I love hearing from you and being assured that the Zeppes have not got you.

As to my breaking down, no; nobody need worry. I think I can stand it all right, accidents apart, of course. And so long as I can hold on, I feel I ought. It is not to praise myself that I say it, but we are no longer allowed to have trained paid nurses here, and of the par-

tially trained, I am the best. Partly because I have had an exceptional chance with my doctor friends in Spain, and partly because I have a funny kind of brain that goes for essentials. The result is that my major takes the worst cases for my division and then does not look at them for days together. I keep a slate hung up, on which I mark the number of the bed where there is a wound I mistrust, or some change that I do not understand, and those are the only cases he looks at. I am thankful to say that all my wounds are clearing up at last, and the men doing well—all except one who has typhoid, and I have him in a room apart. Things are made unnecessarily hard for us here. There is a typhoid ward, and it would have lightened my labors to send my man there, but by the time typhoid symptoms appeared, they had filled up the said ward with the lice-covered clothes, so I had to keep him, and most of the time I am too busy to do everything myself, and must trust to the obedience of an ignorant orderly to do the rest. Also, instead of our men's clothes being changed before they came to their ward, they were sent up as they were, and we were not allowed to take the clothes out of the ward until each man's possessions had been *numérotés*. It took the corporal two days to do my division, and by that time my nice clean wards, cleaned under incredibly difficult circumstances, were, and are still, crawling. I am not exaggerating; I spend my life trying to oust them—hateful, disgusting! I wear an antivermin belt myself, and finding that they got on to my feet and ankles, I cut up a belt and wrapped pieces round my ankles and knees under my stockings. That settled them. If ever they get past my ankles, they perish in the second trenches at my knees. Of course, it spoils the appearance of my ankles, and in a hospital where all the administration is masculine, it requires some courage to know that one looks like a very fat woman whose calves have slipped. Since I wrote you last, we have had no fresh wounded, consequently life is easier. Yesterday I got off at 4 p. m. and had a walk—the first in three weeks, Sundays not excepted. Consequently, today I am once more full of beans. In other ways also things are better now, some fresh ladies came out and I have been allowed two, one who had already served two months in another division, and one quite new. For that I thank the major, as I think he had a fight for it. One lady helps me in the *salle de pansements*, and the other does ward work, so there is a hope of once more being straight and clean. Even now we are only twelve to this huge hospital; I know several who would and could come and help, but a military hospital is hedged in by red-tape entanglements, and until a new order comes, we are not allowed more. However, our *mdecin-chef* is convinced of the need for more, so perhaps he may succeed in getting permission soon. Until then *animo v adelante*. . .

12 December, 1915.

. . . I am so looking forward to Christmas Day; we told our wards we should have a tea and they are pleased! In my division some of the not-so-ill are going to sing, and some are learning up things out of the comic papers to recite. And they have no inkling of the little presents in store for them; that will be quite a surprise. I shall do up each gift in paper with the name on it because they love to be known to us by name. In the hospital they are numbered according to their beds, and I find it easier to remember them by their wounds, especially as my major never knows them by anything else; they are *celui de l'épaule fracturée, l'amputé de la jambe, l'ostéite du tibia*, etc., but once I was told that they spoke with approval of me because to me each man was *un être et pas un numéro*, so now I learn each name as he comes in, and I am usually just getting the name thoroughly connected with the wound and the face when the man is considered well enough to move on to a convalescent hospital. . . .

We enjoyed your hospital stories. This is the best I had heard before:

"A Highlander was dying in a hospital ward somewhere in France, and he begged and begged to be allowed to hear his native music once more. So a piper was brought, and the Highlander was so greatly cheered that he took a turn for the better and recovered. But all the rest of the ward died."

29 December, 1915.

. . . Today I am rather sad and lonely; two of my *anciens* have been discharged; they were here already when I came, and were hitherto never quite well enough

to be evacuated. Since they have been up and about they have waited on my hand and foot, and were always discovering some new thing they could take off my hands. Also they were such nice fellows, and one especially was full of *esprit*. He is an infantry corporal, and in peace time was chief cashier in one of the large champagne houses. He has one month's leave and then back to the trenches; and my major, who likes him immensely, says it is murder, because there is one spot in his right lung which has never properly healed. The major says he will never get over the wound quite, and a wet night or two will be enough to kill him. Yesterday he was called rather hastily to the *conseil de convalescence*, and when he got back, he lay down on his bed and I could hear his breathing all down the ward. Ten minutes later he was back in the *salle de pansements* to cut dressings for me. Today the *écueux* left at 7 a. m., but when I went on duty, I found everything ready for me, instruments sterilized, hot water on the boil, disinfectants all prepared, etc., and the *blisses* told me the corporal had been getting things ready since before six. You will realize how hardened I am getting when I tell you that I got through the day's work without poisoning every wound with my tears.

5 February, 1916.

My division has been evacuated until I have only twenty-nine men. I had intended to take it easy a little as soon as I had got the beds disinfected. The *médecin-chef* leaves it to me to arrange the work as I think best and take any time off that I like, so I had looked forward to an afternoon or two off. As luck would have it, a telegram has just come, telling us to prepare for two hundred and four wounded. They are expected at 3 a. m. That means that we tumble up by 2:30 and put cocoa on the stove and hot water ready to clean the men. Then they probably won't arrive till 5 or 6; meanwhile we hang round and shiver and have whispered conversations with any poor dear who may be awake. This sounds like a grumble, but really I am happy, as much so as I could be while the world is full of hatred and suffering. You know a woman cannot be really unhappy while she is adored by never less than twenty-five men at a time! I never thought there could be such gratitude in the world as I get for my small services. The other day I had a man amputated nearly up at the thigh. Of course, he might easily have a hemorrhage after that; so in the night I stole down the ward to raise the clothes and see whether there was any leakage. I went very quietly to awaken no one. But the beds are very near together, to accommodate as many as possible, and as I turned away, satisfied, I was suddenly seized by the man in the next bed: 'Mademoiselle, chère petite mademoiselle, vous pensez à nous quand vous devez vous reposer. Que les Anglaises sont gentilles, jamais je ne les oublierai!' and I crept away with my heart warm and my hands a mass of kisses. You see, Uncle, I could not be better paid, and it even gives me pleasure to be known everywhere as *la petite mademoiselle*.

Must go to sleep. I hope you do not mind my letters being untidy. I write them in bed so as to rest all I can.

* * * *

THE ANGEL OF MERCY OF THE UNITED STATES NAVY*

The Distinction Between the Hospital Ship, the Ambulance Ship and the Transport—Arrangement and Equipment of the Hospital Ship "Mercy"

There is some confusion in the minds of people ashore, says N. J. Blackwood, commanding officer and medical director, U. S. Navy, writing in a recent number of the *American Journal of Surgery*, as to the distinction between hospital ships, ambulance ships and transports for the wounded. These terms are easily understandable, if one will liken the hospital ship to the hospital, the ambulance ship to the ambulance which brings the patients to the hospital, and the transport for wounded to the train or other conveyance that might be used to carry large numbers of sick and wounded from place to

place. The hospital ship is merely a floating hospital—a vessel equipped with everything that pertains to hospital use for the care of the sick and injured, whose duty is to attend the fleet at its base and care for all cases of illness and injury originating in the fleet, who, with a fair degree of certainty, may be able to return soon to their respective duties on their respective ships. It is not a part of the function of the hospital ship to transport sick and wounded from the fleet to a base hospital ashore, or to transport sick and wounded across the ocean. Its equipment is far too elaborate for any such purpose, and the spaces allotted for the different departments are too small for the accommodation of large numbers of such casualties.

The hospital ship should remain at the fleet base to repair the personnel of the fleet and return it to its duty, and, unless it should become overcrowded by an excessive number of patients, it should remain at that fleet base or move from one fleet base to another when the fleet itself changes its base. It should never, under any circumstances, be separated from the fleet or its main base, but always should be at hand.

It should not be required to take care of any very large number of contagious cases, because these cases may be numerous but mild, and the hospital ship would soon become overcrowded with these cases. Every fleet should have, in addition to a hospital ship and an ambulance ship, a contagious disease hospital ship.

The ambulance ship, the analogue of the ambulance attached to a hospital, should be a ship of moderate size, capable of carrying from 100 to 150 cases, and so arranged as to be able to segregate the various kinds of contagious diseases, and also the medical, surgical and other cases that it might carry from the fleet to the base hospital ashore. This ambulance should make periodical trips from the fleet and transfer the cases of illness and injury which are apparently destined to a long convalescence or whose convalescence will be more rapid ashore, and also to relieve any congestion on board the hospital ship itself. The equipment of the ambulance ship is simple, its principal needs being a small operating room and large dressing room for renewing dressings and performing minor surgery, with large spaces for ambulant cases and a sufficient number of bunks to accommodate the more seriously ill. Its galley accommodations should be of the emergency type, but capable of quickly furnishing special diets and meals for the total number of patients that it can carry. The trips made by the ambulance ship would, in all probability, be short, occupying not more than five or ten hours, and the patients, therefore, would require attention and care only during that period. A fairly large staff of nurses might be necessary but the medical and surgical staff could be comparatively small.

The transport for carrying sick and wounded long distances is altogether a different proposition from the hospital ship and occupies a position midway between the hospital ship and the ambulance ship requiring less equipment than the hospital ship and yet more than the ambulance ship. Any large transport could be easily fitted for this purpose, requiring merely in addition to its equipment for ordinary transport purposes, operating and dressing rooms of sufficient capacity, and a large enough corps of nurses and medical staff to take care of the patients for a period of two or three weeks. Major operations would be performed only in an emergency, and the duties of the personnel would be to renew dressings and care for the ordinary every-day necessities of convalescent and convalescing patients.

*The illustrations accompanying this article are here presented by courtesy of the American Journal of Surgery.

Before the present war began, the United States possessed but one hospital ship, the "Solace," which was a converted merchantman and had been in service as a hospital ship about nine years. Since war was declared, the navy has added two more hospital ships to its fleet, the "Mercy" and the "Comfort," two ex-Ward liners. As



Fig. 1. The hospital ship "Mercy."

the "Mercy" and the "Comfort" are sister ships, the description of one will serve for both.

The "Mercy" is a ship of about 10,000 tons displacement and is fitted with every modern appliance for the care and treatment of the sick and injured. The conversion of a merchant ship into a hospital ship is a very difficult proposition, and the ideal hospital ship will never appear until it is built from the keel up. Such a ship has been appropriated for by Congress and has been started, but the necessity for ships of other character has delayed its completion. In converting the "Mercy" into a hospital ship, the endeavor has been made to place the wards for the more seriously sick—the operating rooms, laboratories, etc.—on the upper decks where natural light and ventilation can be utilized to the full, and to locate below on the lower decks such wards and rooms as would accommodate the convalescing, the ambulant cases, and the departments which are not so dependent upon natural light and ventilation. We therefore find on the upper or promenade deck, from forward aft, first the operating suite, then the sick officers' ward and convalescent officers' rooms, and abaft these, the isolation wards for contagious diseases. On the deck just below, or hurricane deck, are placed the surgical ward immediately below the operating suite and connected to it by an elevator, the dental office, dressing room, diet kitchen, dispensary, x-ray room, laboratory, medical ward, and their accompanying appurtenances. Both these decks are above the hull and therefore have through-and-through ventilation and large windows for natural light.

On the main deck are the prophylactic room, the x-ray developing and study room, the eye, ear, nose and throat operating room and ward, and the genito-urinary and large convalescent ward.

The rest of the ship is taken up with quarters for the crew and the hospital corps, and storerooms and machinery which are necessary for the upkeep of the hospital as well as of the ship.

The operating suite, the contents of which were donated by the Colonial Dames of America, consists of operating room, sterilizing room, instrument room, anesthetizing room, scrub-up room, and pus operating room. The gen-

eral operating room is a model in equipment. The only difference between this operating room and those ashore is the fact that everything must be secured to the deck in its proper place, and is, therefore, not ordinarily movable. The room also has a portable pantostat machine for cautery work of all kinds. A certain amount of natural light comes in through the large ports on all sides, but a fine set of electric lights is furnished over each of the operating tables and also at different places throughout the operating room.

The rooms in the operating suite are tiled, sheathed, and painted with white enamel paint.

The surgical ward, just below the operating room, has space for fifty-four bunks arranged in two tiers, with a possible expansion capacity to nearly double that number. The bunks are of the tubular iron type with wire woven springs, and many of them are fitted with the Goetz adjustable springs for placing patients in the Fowler position.

Four operating teams could work simultaneously, which means that the capacity for efficient surgical work is enormous and probably exceeds anything but the gravest emergency. In order to promote efficiency and cooperation, the head of the surgical department has also general supervision over the roentgenology, genito-urinary, and the eye, ear, nose and throat departments, while a close association is maintained with the medical department, thus giving all patients the benefit of the knowledge and abilities of the various specialists in these departments.

The ward for sick officers contains eight beds and six rooms, the former for the more serious cases requiring

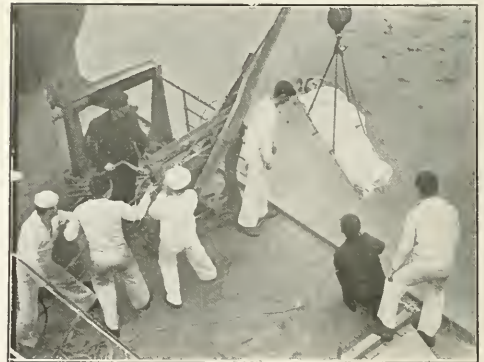


Fig. 2. Transferring a patient.

constant attention of the nurses, and the rooms for the less seriously ill and convalescent cases. This ward, like all the others, is fitted with every convenience that ingenuity and thoughtfulness could dictate. A large and comfortable mess room is provided for the convalescent officers, and a dumb waiter connects this mess room with the neighborhood of the galley and special diet kitchen on the deck below. The linen room for the general distribution of linen on this deck is situated just abaft these quarters and in this room all of the repairing and distribution of the linen takes place. From this point to the after end of the ship are the contagious disease wards, five in number, with a total capacity of forty-two bunks and the possibility of expansion to at least three or four times that number for temporary accommodation.

On the after end of this deck is found an enclosed space for a solarium, which will be utilized for the over-

flow of contagious cases, and, when no contagious cases are being housed, for the recreation of convalescent patients from all of the other wards. This solarium hospital treatment will enable the patients to live practically in the open air and sunlight and at the same time to be protected from all bad weather conditions.

Just abaft the surgical ward, on the starboard side, are the administration offices and the pay office, and next to them the office of the dental surgeon.

On the port side, opposite the offices just described and abaft the surgical dressing room, is the diet kitchen, containing electric range, pasteurizing machine, steam cooker, coffee urns, and sink, and capable of providing special diets for all the wards. Just abaft the diet kitchen is the x-ray room, equipped as completely and perfectly as experience and careful selection could devise. The foundation of the installation is the current generator or transformer, which is of the most modern type and of greatest capacity of 12 kilowatts. This has been especially altered so as to adapt it to use aboard ship by the addition of a number of features not required under ordinary hospital conditions ashore.

Just abaft the x-ray room is the laboratory, with good, natural light and ventilation, and equipment of the latest improved type, well adapted for all required chemical and pathological examinations, including urine examination, chemical and microscopical; complete chemical and microscopical examinations with bacteria determinations by inoculations or cultures; stool examinations, chemical and microscopical; all ordinary tests with special reference to determination of intestinal parasites, amebas or

determination of type; preparation and standardization of autogenous vaccines; pathological diagnosis of tissues. In connection with this laboratory is an extensive animal house on the boat deck containing compartments for guinea-pigs, rabbits, sheep and fowl, all of which are provided and cared for under the best conditions possible.

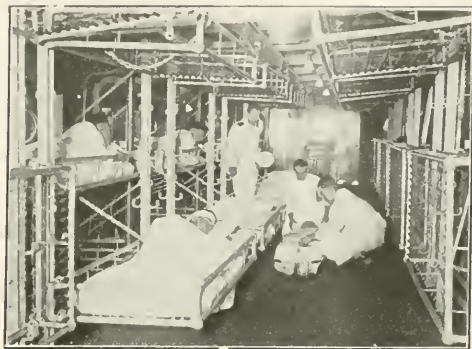


Fig. 4. The surgical ward.

This brings us to the portion of the ship where the medical officers live, and just abaft this is the medical ward. This strictly medical ward contains thirty-six beds and is for the use of the active and purely medical bed patients. The light and ventilation are natural, supplemented by artificial light. Everything that is ordinarily found in the medical ward of a hospital is present here. The accommodations of this ward can easily be expanded, and it is flanked on either side by a good, wide, open deck on which convalescent patients may lounge in long chairs and get the benefit of open air and sunshine. Aft the medical is the autopsy room, this being so placed with regard to the patients as to remove all objectionable suggestion of possible unfortunate termination to those who are still in a precarious condition.

The eye, ear, nose and throat ward is situated forward on the main deck just below the surgical ward, and, like all other wards, is fitted with the necessary appurtenances for the proper care of the sick. The operating and examining room for this department is completely equipped in every respect and is much more fully supplied than the average specialist's office ashore. All minor operations, as well as special treatments, will be done in this office while under normal conditions and in an emergency, should the general operating room be not available, major operations could be performed in this room.

At the after end of this deck and immediately under the medical ward is situated the large genito-urinary and convalescent ward, which contains 136 bunks arranged in two tiers and is capable of expansion to probably 200. In the after end of this ward is a separate room for venereal treatments.

This comprises the chief features of the hospital departments proper, but there are many accessories which are essential to the support of the hospital as well as the upkeep and care of the ship itself. Of all these accessories, there is none that can compare for usefulness and advancement in equipment of modern hospital ships with the "mechanical cow," a machine which has been but lately put on the market and bids fair to solve the problem of milk supply for the sick on hospital ships when

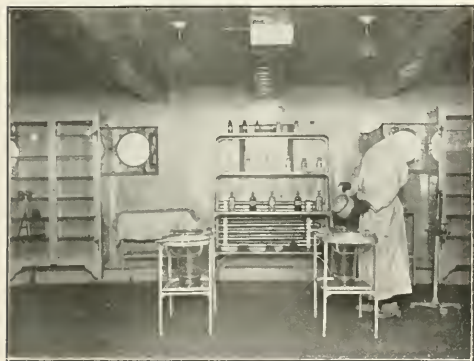


Fig. 3. Corner of operating room.

pathogenic bacteria; gastric analysis, chemical and microscopical, and detection of common poisons; sputum examinations, chemical and microscopical, with reference to detection of pathogenic bacteria and their isolation; throat swab smear examinations and cultures; blood examinations, including the determination of blood urea and blood sugar; complete microscopical examination for determination of blood cell changes or detection of blood parasites; blood cultures for detection of presence of pathogenic bacteria; serological examinations; complete fixation reaction of lues; tuberculosis, and chronic Neisserian infections; agglutination reaction with special reference to determination of immunity; examinations of body fluids, transudates and exudates; bacteriological and cytological diagnosis; spinal fluid examination complete; determination of carriers, typhoid, diphtheria, meningitis and virulent pneumonia, micro-organisms with

at sea or removed from a base where good milk can be obtained. The milk produced by this machine is made from a combination of unsalted butter and skimmed milk powder, and can be produced with any degree of butter fat required. Cream that will whip is also a product of this machine, and it all tastes like the very best dairy milk and cream that one can get anywhere, and really



Fig. 5. The solarium.

is so. By means of this machine, 15 gallons of cold, pasteurized milk can be produced in 45 minutes, and if more is required the operation is simply repeated, whereas if an excess amount is produced, it has only to be placed in the milk cans and put in the cold storage room where it will keep indefinitely just as fresh dairy milk will do. An ice-cream machine, run by electricity and controlled by one man, for making ice cream in large quantities, will make ten gallons at a time, and is for use when large quantities of ice cream are desired, but is supplemented



Fig. 6. Guinea-pig room.

by simple quart and pint freezers for individual diets for the sick.

The cold storage plant is large enough to carry fresh provisions for from three to six months, so that the hos-

pital ship is absolutely independent of outside aid for that period at least. In connection with the cold storage plant is a refrigerating machine which will produce, under favorable circumstances, a ton of ice a day, besides furnishing the refrigeration for the cold storage, "mechanical cow," mortuary, and the refrigerating rooms where meats, eggs, milk, and other fresh provisions are kept for daily issue up to the amount of one week's supply.

The distilling plant, consisting of evaporators and distillers, is sufficient to furnish 35 gallons of fresh water a day per capita for 600 people, which will insure plenty of fresh water for the sick and crew for all necessary purposes. Two large disinfectors of the American Sterilizer type are built in at the after end of the contagious wards and are capable of disinfecting large numbers of mattresses, bedding, and even furniture, which may come from the contagious wards.

A mortuary, where bodies may be placed in cold storage after having been properly embalmed and put in



Fig. 7. Mechanical cow or milk separator.

metal caskets, is presided over by a registered undertaker and embalmer and, it is hoped, is far too large ever to be filled, though it has been constructed with a view to the excessive number of dead under war conditions.

The galley or kitchen and commissary department is under the direct management and control of the paymaster of the ship and is fully capable of providing foods of any kind, except the special diets, for at least six hundred people, containing as it does, all the modern appliances of ranges, steam cookers, electric ovens, coffee urns and bakery, of modern and most approved type.

In the after end of the ship, on the main deck, is situated the laundry, which is equipped with all the best and most modern type of electric laundry machinery, including washers, tumblers, extractors, pressers, mangles, ironers, shapers, dry room, and all the accessories found in the well-known steam and electric laundries.

There are, besides the accessories already mentioned, many others, such as the carpenter shop, machine shop, electric shop, storerooms for dry provisions, medical and surgical supplies and dozens of other things which readily occur to all those familiar with requirements of hos-

pitals. All necessary means of amusement have been provided for convalescents.

The government has supplied a good fiction library, which has been supplemented by contributions from various sources. A liberal supply of games for the amusement of those who are confined to their bunks, and are not able to get about the ship, has been furnished by patriotic persons. Provision has been made for all of the American athletic games, such as baseball, swimming, boxing, etc., and all hands are encouraged in perfecting themselves in rowing, sailing and swimming.

The spiritual welfare of all hands is looked after by the chaplain, who, in addition to the religious duties which belong to his profession ashore, has charge of all the amusements and entertainments.

* * * *

RED CROSS CONVALESCENT HOUSE AT WALTER REED HOSPITAL

Soldiers and Sailors Thrive in "Homey" Atmosphere—Accommodations for Mothers—Forty-Three Other Houses Stationed at Convenient Posts—Recreation and Informal Surroundings

This convalescent house at the great Walter Reed Army Hospital in Washington is one of forty-four such homes which the "greatest mother in the world" has built or is



Fig. 1. Front of the Red Cross Convalescent House at Walter Reed Hospital, Washington, D. C.

building to help her sick soldier and sailor sons—men returned from France or newly drafted privates—back to health and happy usefulness. In connection with every hospital at all the great camps in America, the American Red Cross is providing one of these "stations on the road back to strength." And the "greatest mother" has a place also in her home for other mothers. She has provided on upper floors twelve comfortable bedrooms which are for the accommodation of mothers or relatives summoned to the hospital, who thus are enabled to spend their entire time within call of the bedside.

To the men who are convalescent, the American Red Cross says "Drop over home. Don't bother to dress. Only the home folks. Come as you are." "Come as you are" to a man just allowed to get out of bed and wild to get away from the smell of iodoform and scenes of sickness, means bathrobe and slippers. And these are full dress, day or evening, in these clubs which seek to restore strength through comfort, rest, sunlight, air and plenty of wholesome recreation.

A few steps from the wards or a few pushes on the wheel of a rolling chair from all the big hospitals bring

convalescents into this lively place where no one has time or opportunity to talk about his troubles. If the surgeon has suggested a sun bath, a big solarium or sun porch invites him to lounge in comfortable chairs or on mattress swings. The broad screened-in porch provides the fresh-air cure in pleasant company and with all sorts of games available on easily moved tables. Here, too, the



Fig. 2. In the sun parlor, Red Cross Convalescent House.

smokers gather to discuss the war news and "go over the top" with the newspaper strategists.

The main lounge which opens into the solarium ordinarily is a large homelike parlor and reading room furnished with wicker and lounging chairs, big divans, tables, book shelves, writing desks and special recreational equipment, including two phonographs and a player piano. It is on occasion used as an amusement hall for presenting shows, concerts, and movies.

Just off the main lounge is the mail room, library filled with specially chosen books and periodicals, the information desk, and the supply department. A kitchen and pantry is just beyond it, ready to handle the mess for the Red Cross staff, if necessary, or to serve as a special diet kitchen, in preparing unusual dishes for convalescents. The Red Cross will give the lower floor of one of the two wings over to the Y. M. C. A. for use as a billiard and pool room and as headquarters for "Triangle" activities which apply to the sick.

The furnishings of the Red Cross rooms are provided by the local Red Cross chapters. Many individuals and organizations contributed, and several of the guest rooms were furnished as memorials. The diversional equipment



Fig. 3. The lower floor of one of the wings is given over to the Young Men's Christian Association for its activities.

provided by the Red Cross was assembled under the direction of Miss Jane A. Delano, head of the department of nursing. Men and women Red Cross workers, specially

selected for ability to assist convalescents will be on duty day and evening to do everything possible to make the men comfortable.

These convalescent houses also will serve as headquarters of the Red Cross Communication Service and Camp Service in each locality. Through these services, the men at camps and hospitals can keep in touch with their families, and relatives and friends can get constant news of patients' progress. Soldiers worried about the condition of their families can, through the Department of Civilian Relief, put into instant operation Red Cross agencies charged with seeing that the dependents of a soldier do not lack for any essential that it is possible for the American people to provide.

These houses are being provided in connection with army hospitals at the request of the Surgeon General. They will be built also at all important naval hospitals. For the erection of the fifty or sixty which may be needed, the Red Cross has set aside \$512,000. In addition to that at Walter Reed Hospital, houses are now open at Camp Upton, L. I.; Camp Devens, Mass.; General Hospital No. 1, New York, and Camp Dix, N. J. Similar convalescent houses are being rushed to completion at the following thirty-nine camps and hospitals: Camp Meade, Md.; Camp Gordon and Camp Hancock, Ga.; Camp Jackson, S. C.; Camp Logan and Camp Bowie, Texas; Camp Wadsworth and Camp Sevier, S. C.; Camp Custer, Mich.; Camp Stuart, Newport News, Va.; 5th Naval District, Norfolk, Va.; Ft. Oglethorpe, Ga.; Camp Taylor, Ky.; Camp Sherman, Ohio; Camp Wheeler, Ga.; Camp Travis, Texas; 1st Naval District, Chelsea, Mass.; General Hospital No. 3, Rahway, N. J.; Camp Merritt, N. J.; Great Lakes, Ill.; Camp Shelby, Miss.; Hoffman Island, N. Y.; Camp Dodge, Iowa; Ft. Sam Houston, Texas; Camp Cody, N. M.; Camp Grant, Ill.; Camp Funston, Kansas; Camp McArthur, Texas; Camp Pike, Ark.; Camp Beauregard, La.; U. S. General Hospital No. 19, S. I.; Mineola, L. I.; Camp Fremont, Cal.; Camp Harry J. Jones; Camp Kearney, Cal.; Camp Lee, Va.; Ft. Des Moines, Iowa; Pelham Bay, New York; Fort McPherson, Ga.

* * * *

Large Portable Sterilizing Machine for Pershing's Troops in France

The largest piece of sterilizing apparatus ever constructed will soon be sent to General Pershing's forces in France. The illustration shows one of the sterilizing



Copyright Underwood & Underwood, New York

machines devised by Dr. Leon L. Watters to minimize the danger of disease among our soldiers. Each apparatus is complete in itself, weighs 8,000 pounds, and has a

steam boiler which provides the necessary high-pressure steam. The portability of these machines permits their use very close to the fighting lines.

By the use of these sterilizers it is possible to take men out of the trenches and send them to one of the many stations where facilities are provided for bathing and cleansing of their bodies while the clothing and effects of the men can be thoroughly disinfected in less than forty minutes in one disinfectant. Surgical dressings can also be sterilized. (Censored and passed by the Committee on Public Information.)

* * * *

One of the Tent Wards Provided by the Brooklyn Navy Yard Hospital for the Care of Sick Sailors.

The tents are erected over a raised wooden platform which permits the circulation of air underneath, keeping



Copyright Underwood & Underwood, New York.

them cool, dry, and clean. Each tent is equipped with hospital cots, chairs, bedside stands, and wire cage lockers for two patients.

* * * *

HOSPITAL TRAINS FOR AMERICANS IN FRANCE

Equipment of Trains—All Modern Medical and Surgical Facilities Provided—Patients Supplied With Every Comfort

The hospital trains for transporting American soldiers wounded in France embody the improvements that have been worked out by the French and British since the first hospital train was built. Our cars are firmly built, attractive, and, on the whole, resemble a "coast-to-coast" American "limited." Owing to the distance between the battlefield and the United States, necessarily these trains must be supplied by England and France, largely under the direction of the British railway executive committee. The plans for building have been standardized, and building operations are proceeding rapidly.

Maj. Howard Clarke, in a recent issue of the *Medical Times*, describes a standard train with sixteen coaches, including: one infectious car, 18 beds; one staff car, 8 beds; one kitchen and sitting sick officers' car, 3 beds and 20 seats; eight ordinary lying ward cars, 288 beds; one pharmacy car; one infectious case sitting car, 56 seats, 14 upper berths; one kitchen and mess car, 3 beds (for cooks); one personnel car, 30 beds; one train crew and store car; total, 400 beds. The average empty weight of the train, without engine, is about 450 tons, and the average length of the train, without engine, 920 feet. Each "moving hospital" is equipped with conveniences—electric lights, steam heat, electric fans, laboratories, lavatories,



Views of ambulance train: (1) stores car; (2) car for infectious bed cases; (3 and 4) kitchen; (5) ward car; (6) pharmacy and dispensary car. This illustration is shown here by courtesy of the *Medical Times*.

racks for personal belongings, and even smoke trays for the patients' indulgence.

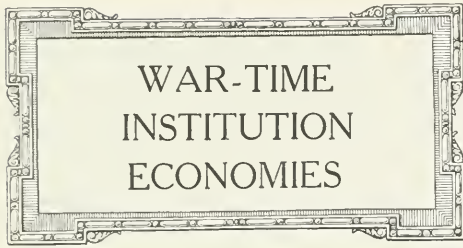
The cases are classified, and the badly wounded, the slightly wounded, the infectious cases and the mental cases are separated for transportation.

Eight ordinary ward cars for patients have each thirty-six beds, arranged in tiers of three. These can easily be converted into seats to accommodate patients who are able to sit up, used for stretchers in emergency cases, or folded

against the sides of the couch when car requires cleaning.

The pharmacy car is placed midway in the series of eight ward coaches, in order that surgical and medical supplies can easily be accessible. This car also contains drugs and linen. In one section is a small room with a collapsible table for dressings and minor operations.

In the kitchen is a heating tank that keeps 50 gallons of hot water ready for use. Another tank furnishes water to drink, making about 2,500 gallons on each train.



HOSPITAL HOUSEKEEPING AND WAR-TIME ECONOMIES*

Compactly Built Hospitals Desirable—How One Hospital Keeps Down Its Bills—Getting the Most Out of Help—A Plan for Keeping a Hospital Clean—How to Make Inspection Tours Profitable

By C. L. BUTTERFIELD, Superintendent, Martins Ferry Hospital, Martins Ferry, Ohio.

The hospital which is compactly built is a better proposition to handle than the one which covers more floor space for the same number of patients. As an example of this point, I have jotted down a few figures from the expense item of a fifty-bed hospital which last year gave 12,099 days' service to patients. The coal bill was less than \$400. Of course, we have the advantage of being fairly on top of the coal fields, and so do not have to pay freight and other incidentals.

A second item which interests me is the expense of our laundry service. Since December we have not been able to hire a laundress, so we have sent all our work out to a laundry in the town at a cost of about \$250 a month. I have consoled myself with the idea that we are spending no more than when we tried to do part of it ourselves. Even if I am convinced later that my idea is wrong, we shall keep right on, as we do not expect to be able to hire laundresses until the war is over.

For two reasons our pay-roll is brief:

1. Our plant is simple, with no complex machinery to handle.

2. We cannot get the help.

We house the housekeeper, cook, kitchen helper, waitress, and janitor, who is our general utility man. In this way we are reasonably sure that our morning work will start off on time. These persons are very important, and we regard them as part of the general family, thus increasing their feeling of interest in the institution. Our housekeeper has been with us eight years, our cook four years, at least, and we are now putting her younger sister in the dining room as waitress.

We plan to have two or three scrubwomen all the time, more or less. This morning it is less, so we hired two young boys to come in for the summer, or at least for a few days, to do some of this class of work. Our scrubwomen who come every morning at 7:30, have two meals served to them; they leave at 3:30, and are paid \$30 a month.

We have raised the wages twice this year and find the help just as migratory as before.

No one needs to lack for work in this community at present. Unskilled labor receives \$3 a day, while steel workers are paid \$10 to \$20 and \$30 a day. In all the mills women are filling the places made by the draft

boards. The only thing that relieves our situation is the drunken husband. If it were not for this form of parasite I do not know where we would find any of this class of helpers, and so we profit by their misfortunes.

Our main stand-by in cleaning up is plain soap and water. We are in such a sooty neighborhood, there is nothing for us to do but wash and scour and repaint when necessary. I am sure we all agree that washing is superior to the ordinary fumigation, and is considerably less expensive. Our floors are covered with linoleum, which we wash and polish with a liquid wax; this keeps them a good color and preserves them also.

We constantly repair, paint, and improve in every way possible. During the last year we have installed as many labor-saving devices as we could afford which met our needs. In fact, if I should name them all, you would wonder how we managed before without some of them. However, with the aid of these appliances we are able to meet the strain of increasing work handled by fewer employees.

Our last purchase was a motor lawn-mower which is the most wonderful help of all, as we have two acres of lawn which, theoretically, could be cut by hand in a week, but which really was never finished. Now the man can do the work in three afternoons easily. We have also changed our type of flower garden, planting shrubbery and hardy perennials instead of annuals, thus lessening the amount of time necessary for their care.

In regard to inspection and supervision, we assign the general hospital and nurses' home to the housekeeper, while the dietitian is responsible for the kitchens and store rooms where the foodstuffs are kept. Often, if there is time, I take a student nurse with me to view the nurses' home, giving her a list of suggestions to be carried out, and the next visit always shows an improvement of former conditions.

The best way to check up on yourself is to escort visitors around the institution personally. In this way you surely see all your own shortcomings in the way of management, and at the same time your inspection does not appear so personal to the heads of the various departments.

I have given you only a plain tale from the hills—simply taking the problem of the physical care of a hospital not from the ideal standpoint toward which we were all aiming a few years ago, but from the situation of today—cutting our garment from our cloth.

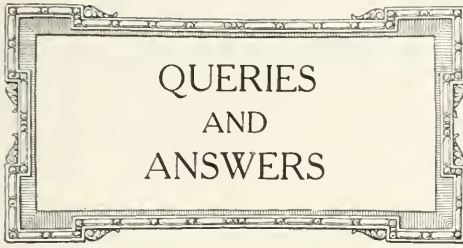
What access have your hospital employees to the food supplies? "Many a mickle makes a muckle," and an orange or lemon or pear occasionally doesn't matter much, but every one of these items "swiped" piles up, and eventually the sum total is measurable. An employee going about eating an orange is an outright invitation to others to locate the source and help themselves.

How much labor are you getting out of your common help? Has each person a definite allotted task? Is that task made out in a practical way and is it based on experience and observation? Or is it based on the housekeeper's or head janitor's favoritism?

The real joy of leisure is known only to the people who have contracted the habit of work without becoming enslaved to the vice of overwork.—Henry Van Dyke.

Remember: Pains are symptoms of life; dead ones never have them.—A. W. Burgess in *Journal of Outdoor Life*.

*Read at the Fourth Annual Convention of the Ohio Hospital Association.



QUERIES AND ANSWERS

The Duties of Interns and Superintendents of Nurses

To the Editor of THE MODERN HOSPITAL:

Kindly give us your best ideas regarding the duties of interns and the superintendent of nurses.

We are trying to have the best of everything and would appreciate an early reply.

A SISTERHOOD HOSPITAL.

We know of no one who is better qualified to define the duties of interns than Dr. J. M. Baldy, president of the Board of Medical Education and Licensure of Pennsylvania, whose two articles entitled, respectively, "The Standards of Hospital Education for Interns" and "Has Every Hospital the Inherent Right to an Intern?" appeared in our June and August issues.

The duties of the superintendent of nurses must vary, of course, with the size of the hospital. Formerly, before nursing education had reached the place of standard it now occupies, and before the superintendent of nurses was considered as an officer of the hospital, the woman occupying this position was a general utility nurse and filled in wherever she was needed, in the operating room, in the planning and supervising of diet, in the housekeeping and office work, and even on floor duty when the emergency arose. In consequence, this woman, who should have had her time free for the proper supervision of the theoretical and practical training of her nurses, was used as a nurse instead of an executive.

This has always been one of the causes of the neglect of nursing education in smaller hospitals. In many instances, even where the hospitals had grown beyond the use of a superintendent of nurses, doctors and superintendents still clung to the old traditions that the superintendent of nurses must be personally present in many places where the work could very well be done by pupil nurses. The executive work really required by the head of the training school had to be neglected, in consequence.

A superintendent of a training school is one of the officers of the hospital and entitled to sit at the council table in any questions of importance which involve the nursing care given in the institution. She should, of course, have her own office, well equipped with proper files to care for the records of the nursing care of patients and the nurses' education. In a hospital of more than seventy-five beds she should have one of the graduates employed as her assistant. She should have proper living quarters, a suite, if possible, with bath.

The duties of a superintendent of nurses consist of her supervision of the training school and of the nursing care of the patients in the hospital. This means that all matters pertaining to this nursing care which is given to patients by her student nurses and supervising nurses must be her responsibility. All graduate supervising nurses should report to her and be subject to her orders. All requisitions for supplies connected with the nursing care of patients should come through her office and receive an O. K. there before being filled. All matters of

complaint on the care of patients and discipline of the nurses should be referred to her. The time of all nurses should be arranged in her office, as well as all matters pertaining to the nursing education of the training school. The superintendent of nurses is the executive head of the training school and the hospital officer who is responsible for the nursing care of the patients, the education of the nurses, and their physical and social welfare.

We appreciate the privilege of assisting such a hospital as our correspondent in obtaining "the best of everything." The desire to do so furnishes further evidence of the progressive spirit evinced by many of the hospitals controlled by sisterhoods.

Written Versus Oral Instructions for the Hospital Staff

To the Editor of THE MODERN HOSPITAL:

A copy of the rules and regulations of our hospital is being sent to you. They were revised last year. We have always felt it advisable that the printed rules and regulations be limited as much as possible, and that they be comprehensive, but not go too much into detail. With the resident system in vogue, we depend upon the older members of the staff to instruct the incoming men in hospital precedent and routine. In fact, we depend upon the residents to exercise a certain amount of supervision over the conduct of the members of their staffs. We have always felt that this plan has worked out pretty well, but with the increasing size of the staff, although at present it is reduced, and with present conditions—that is, having fewer men on the senior staff—the question has arisen whether we ought not to consider formulating a set of rules which enter more into detail for the guidance of the staff. I should like to know what your experience has been and what is your opinion in regard to having a set of rules which cover the details of hospital procedure for the conduct of men on the different services.

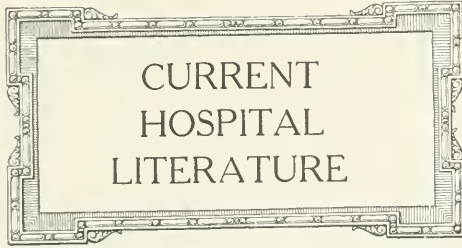
SUPERINTENDENT OF A TEACHING HOSPITAL.

The question that you raised about the relative desirability of printed rules representing either a mere skeleton of the practice of the hospital or a very complete, comprehensive, and detailed description of its methods of internal procedure is one of considerable interest from an administrative standpoint.

With you we lean toward elasticity in hospital administration, believing that the word-of-mouth method of giving instructions is the best method in a small institution where there is constant and intimate contact between the executive and his subordinates and where in the regular course of events a very large proportion of the daily routine of the hospital comes under the immediate personal notice of the executive.

When, however, an institution begins to be a sizable affair, when the administrative work is necessarily split up into many departments, each with a more or less independent and autonomous executive officer, when the mass of administrative detail becomes so great that much of the work of supervision must necessarily be deputed to assistants and subordinates of various grades, it becomes desirable to put into written form and thus to make accessible to every member of the staff and to all the workers of the hospital the wishes of the administration concerning the manner in which all procedures, even the most minute procedures where these concern more than one group of employees, should be carried out.

In such a hospital the superintendent scarcely has the time, for example, to meet with new members of the house staff regularly enough or often enough to come to a thorough understanding with them concerning what the hospital desires of them in their official capacities. Hence, it may be found desirable to issue for the house staff a little pamphlet containing extracts from the rules and regulations applicable to this special group.



ALBERT ALLEMANN, M.D., Foreign Literature.
Army Medical Museum and Library, Office of the Surgeon-General,
United States Army.

The Red Triangle Tuberculosis Farm Colony. *Brit. Jour. Tuberc.*, London, 118, XII, No. 1.

The National Council of Young Men's Christian Associations has purchased thirty acres of land at Kinson, in Dorset, where it has established a farm colony for tuberculous soldiers. Only patients in the early stages of the disease are accepted. The men live in wooden chalets distributed over a sheltered and wooded portion of the estate. Each chalet is divided into two sections, each containing two beds. The central building contains dining and recreation rooms, kitchen, and offices. The work is graduated. It consists of cultivating vegetables and fruit, keeping bees, rearing of poultry and pigs, etc. More extensive farming operations, however, will be undertaken later. The colonists receive one shilling each working day. The aim of the institution is not only to cure the patients but to give them a training which will enable them practically to begin life again.

The Woman's Hospital in the State of New York. Founded in 1855. An Historical Sketch. J. R. Goffe, *Am. Jour. Obstet.*, N. Y., 1918, LXXVII, No. 4.

This institution is the first woman's hospital ever established. It owes its existence to Marion Sims, the father of gynecology, and one of the greatest figures in the history of American medicine. Dr. Sims moved from Alabama to New York in 1853. There, by the aid of a number of wealthy ladies, he secured a private building where he opened in 1855 the first woman's hospital. It was a success from the start. In 1867 a new building was erected which was enlarged in 1877. Then in 1902 the hospital buildings were sold and a more suitable place selected. The new hospital was opened December 5, 1906. It has been greatly enlarged and not only is it the first woman's hospital in the world, but it stands today in the front ranks of the institutions of its kind. Many other brilliant names besides that of Sims—Emmet, Thomas, Peasley, Noeggerath, and Welsh—are also connected with the history of this hospital.

The Hospitalization of Patients with Pulmonary Tuberculosis in the Federal Capital. E. R. Coni. *Semana med.*, Buenos Aires, 1918, XXV, No. 8.

The population of the city of Buenos Aires has grown so rapidly that hospital accommodation has become a pressing question. There are no special tuberculosis hospitals. Patients with pulmonary tuberculosis are housed in the Muñiz Hospital, an institution devoted to all kinds of contagious diseases. The building contains 922 beds. The greater number of patients placed there are affected with pulmonary tuberculosis, but in addition to these, the hos-

pital has care of 76 lepers, 58 trachoma patients, 12 syphilitics, besides patients with typhoid, diphtheria, measles, etc. In 1902 the city passed a law that no patients with pulmonary tuberculosis should be received in the general hospitals. But this law could not be carried out because there was no provision made for the hospitalization of the numerous tuberculous patients. The author proposes to devote the Muñiz Hospital entirely to patients with pulmonary tuberculosis and to erect a new hospital for the other contagious diseases.

A Children's Pavilion at the Sharon Sanatorium. V. Y. Bowditch. *Boston Med. & Surg. Jour.*, 1918, CLXXVIII, No. 16.

The Sharon Sanatorium at Sharon, Mass., an institution devoted to the care and treatment of tuberculous women, is about to enlarge its work by adding a children's pavilion. This annex is intended to be a combined sanatorium and school for debilitated children with suspected tuberculosis and for those who are in the earliest stages of pulmonary or glandular tuberculosis. Only patients of refinement, with moderate incomes, will be received. The charge will be ten dollars a week exclusive of laundry.

The Mayo Clinics at Rochester, Minn., U. S. A. A. Tange, *Ziekenhuis*, Amsterdam, 1918, IX, No. 4.

The author, a surgeon of the Dutch navy, visited the famous Mayo Clinic at Rochester. He describes this great establishment in detail and sums up his observations with the concluding remark that "within the limits of attainable perfection the Mayo Clinics form a work of art, science, and social service more complete and farther developed than any institution modern medical science has thus far produced." The article is accompanied by numerous photoprints and ground-plans of the various buildings.

The Course of Instruction for the Wounded of the Biffi Pavilion. E. Medea. *Osped. Maggiore*, Milan, 1918, No. 3.

The instruction comprised a complete elementary course taught in the primary schools of Italy. A number of prominent ladies of the Red Cross gave their time to this work with rare devotion. The school was a great success. The men, many of whom could not read or write, mastered the entire course within a comparatively short time, and the final examination was held with most gratifying results. In answer to those who might fear lest the hospital be turned into a school, the author observes that since many of the sufferers, owing to the nature of their wounds, have to stay a considerable length of time at the hospital, these days may well be employed to prepare the patients for a useful future life.

The Operation Barrack of the Board of Surgical Ambulances of the Army. Riv. di ingegneria san., Turin, 1918, XIV, No. 3.

This operation barrack was designed for the Italian army by order of the Ministry of War. It is a dismountable barrack of wood, 7 meters (nearly 23 feet) square and covered by heavy tent cloth. A partition divides it into two rooms of 7 by 3.5 meters each. One of these is the operation room proper. Its three outer walls are almost entirely formed of windows. The other room serves for the reception of the wounded. It contains a small dark-room for an x-ray apparatus. The floor is of wood covered with linoleum. The barrack is electrically lighted, and three coal oil stoves furnish the heat. The

operation room contains two operating tables. The barrack is so constructed that each half can be mounted separately if the nature of the ground requires it. It is expected that this barrack will solve the difficult problem of rapidly supplying any part of the front with the necessary surgical facilities if the occasion demands it.

The New Lying-in Hospital in Arezzo. L. Pagliani. Riv. di ingegner. san., Turin, 1918, XIV, No. 4.

As in many European cities, the hospitals of Arezzo are of antiquated construction and do not come up to the standard of modern hygiene. The city has now decided to construct a great new general hospital on the pavilion plan. The obstetrical pavilion has already been completed. It is a fine, substantial three-story structure built of white stone, located on the top of the hillside on which the other pavilions of the future hospital are to be erected, and faces south-east. The first floor contains rooms for the nurses, the kitchen, store-rooms, etc. On the second floor the left wing is taken up by the obstetrical section and the right by the gynecological department. The third floor is entirely devoted to the care of babies. A special division is set apart for the illegitimate children.

Sanatoriums for the Tuberculous in the West of the United States. J. B. Pons. Eco científico, Ciego de Avila, Cuba, 1918, I, No. 5.

The author visited a number of sanatoriums in the Western States. In Denver he paid a visit to the splendid Home for the Tuberculous of the Episcopal Church. This building is situated 6,250 feet above the sea and overlooks the flourishing city of Denver. The Glocker Sanatorium at Colorado Springs is 6,000 feet above the sea and can house 40 patients. The Colorado Sanatorium at Boulder lies at an altitude of 5,300 feet, permitting the patients to enjoy a beautiful view of the mountains of Colorado. Bellevue Sanatorium in Colorado Springs is 5,280 feet high and is more of a clinic than a sanatorium. The author was much impressed with the splendid Pottenger Sanatorium, situated in a beautiful region 14 miles from Los Angeles. Besides a number of pavilions, it has 60 isolated neat bungalows surrounded by small flower gardens. The whole makes a very pleasing impression.

The New National Tuberculosis Sanatorium "Santa Maria." D. Cabret. Riv. de derecho, historia y letras, Buenos Aires, 1918, XX, January Number.

The mortality from tuberculosis in the Argentine Republic has been steadily increasing during the last few years. Over 13,000 persons died from tuberculosis in 1916. This mortality is higher than that of England, Belgium, the United States and several other countries. The coast regions, where the mortality reaches 1.55 per thousand inhabitants, is more exposed to the disease than the interior. The struggle with tuberculosis was organized in 1901, when the Argentine League Against Tuberculosis was founded. Through the initiative of this organization a number of large sanatoriums were established which have since been taken over by the government. In 1910 the Congress of the Argentine Republic passed a law for the erection of five new sanatoriums, three in the mountains and two on the seacoast, and for the establishment of sixteen antituberculosis dispensaries distributed among the larger cities of the country. The services of two Swiss architects, who have had great experience in such constructions, were obtained. The plans were based on the well-known tuberculosis sanatoriums of Davos and Leysin,

Switzerland. So far only one, the Santa Maria Sanatorium, has been completed.

It is situated in the Cosquin valley, on the Argentine Northern Railway, at an altitude of 760 meters (nearly 2,500 feet) above the sea. It consists of thirteen large pavilions and has room for 782 beds. Two large galleries have been constructed for the application of heliotherapy. Special insolation beds, invented by Dr. Rollier, are used for this purpose. The houses have been constructed of the best material, and the whole group of buildings has a pleasing and most imposing aspect. The total cost was \$1,810,000, or \$2,315 per bed. The author states that the Argentine Republic has now hospital accommodation for 21,000 tuberculosis patients, but that 42,000 more beds are necessary to fill the needs of the country.

The Hospital for Nervous Diseases Villa del Seminario at Ferrara. G. Boschi. Med. nuova, Rome, 1918, IX, No. 1.

Very early in this war, it became evident that special institutions were needed for the care and treatment of soldiers who suffered from nervous and mental disturbances due to modern warfare. In October, 1915, it was decided to establish such a hospital at Ferrara, and Cardinal Boschi, archbishop of Ferrara, generously placed his beautiful Villa del Seminario at the disposal of the Italian army medical department. The villa is located about two miles from the city in the beautiful plain of Ferrara. The hospital has 200 beds, 30 of which are set apart for officers. The methods of treatment are psychotherapy, hydrotherapy, massage, thermotherapy, electrotherapy, light work, games, such as croquet, foot-ball, etc., and sojourn in the blue-room. The hospital has a number of rooms entirely colored sky-blue and with blue windowpanes. The effect of the blue light is very beneficial; it allays tics and spasms and quiets the patient.

Hospital for Limbless Men. Cardiff, Brit. Med Jour., Lond., 1918, I, Feb. 23.

This hospital was opened by the Prince of Wales on February 20. It is designed to meet the needs of soldiers and sailors who have lost limbs in the war, but it is intended to be a permanent institution for the benefit also of men crippled by accidents in agriculture or other industries. The hospital is the gift of public-spirited citizens of Cardiff. As it is necessary to test artificial limbs in actual use, a "parade hall" was established. Here the men make their first steps with their artificial limbs between two parallel bars, a mirror in front showing them their errors. In order to obtain the exact length of the artificial limb, the man walks on boards of varying thickness. For men who have lost both lower limbs, a special appliance, an "aerial transporter crutch," has been devised, consisting of pulleys and tackle, by which they can lift themselves from their wheel-chairs into the artificial limbs. The training of men in the use of artificial arms is superintended by an armless collier, who has himself invented an ingenious worker's arm. The artificial limbs are made on the spot, so that it is easy to carry out minor adjustments, and no man is discharged until he finds his limb comfortable.

Male Divisions Intrusted to Female Nurses in State Hospitals for the Insane. G. De Paoli, Quaderni di psichiat., Genoa, 1918, V, No. 2.

As many of the male nurses in the Hospital for the Insane at Genoa were called into the army, the director decided to employ female nurses for male patients, as far as possible. The patients were carefully selected and placed in two separate pavilions of fifty beds each. These

pavilions were entirely entrusted to the care of female nurses. The results have been most gratifying. Women are more patient, gentle, and devoted to their work than men. The patients, old and young, show profound respect toward their nurses and appreciate their services more than those of male nurses. A third pavilion with female nurses has since been added, and, as more male nurses are constantly called to the army, this service will be extended. The hospital conducts a course of theoretical and practical instruction for female nurses. Mothers, wives, daughters, and sisters of men who have lost their lives in the war are given preference.

Laundering Soiled Cotton for French Military Hospitals.

Scientific American, N. Y., 1918, CXVIII, No. 4.

Military hospitals use an immense quantity of absorbent cotton. In Paris alone, the hospitals require more than 4,000 pounds of sterilized cotton a day. Mr. Villey, a French chemist, conceived the plan of cleaning the soiled cotton so as to render it fit for use again. The soiled cotton is treated with chemicals, thoroughly washed in hot and cold water, and dried. The laundering plant at Montferrand alone has a capacity of over 40,000 pounds of laundered cotton a day. As the French government pays about sixty cents a pound for American absorbent cotton, more than a million dollars a year is saved in this manner. It should be added that soiled cotton containing dangerous germs is at once burned.

Necessity of Hospitalizing Typhoid Patients in Order to Secure Efficient Treatment and to Protect the Public Health.

M. G. Lebreton, Rev. de med. y cirug. de la Habana, 1918, XXIII, No. 5.

In Cuba, typhoid fever claims numerous victims, and typhoid epidemics are frequent in all parts of the islands. The author considers contact the most important mode of transmission since, where propagation is due to water, milk, etc., the disease is easily controlled. When an epidemic of typhoid raged in Santa Cruz del Norte and decimated the population, he had all typhoid patients brought to the hospital. In less than ten days, the disease was under control. The author demands that all cases which, by a laboratory examination, have been found to be typhoid fever, be at once hospitalized, and where this is impossible, that hospital discipline be established in the patient's house under the supervision of the public health authorities.

Organized Provision for the Care of the Sick in Massachusetts.

G. E. Whitehill, Boston Med. and Surg. Jour., 1918, CLXXVIII, No. 7.

In answer to the question submitted by the Commission on Social Insurance: "To what extent are wage-earners able to avail themselves of free clinics in the state?" the author makes the following statement:

There are 100 or more hospitals, 39 with out-patient departments, 11 dispensaries, and about 30 nursing associations. These institutions admit patients without regard to race, color, sex, religion, or ability to pay. There is, on an average, one institution for every 32,000 of the population, with an invested capital of between forty-five and fifty million dollars. During 1916, one person in eight and one-half of the whole population was treated at a hospital or dispensary, the average cost being nearly six million dollars. The average stay in the hospital was fifteen days. The income derived from patients at the hospital, out-patient departments and dispensaries, in 1916, was \$3,372,000, the amount of free treatment being \$2,614,000.

The Value and Limitations of Sanatorium Treatment for Tuberculosis.

St. Clair Thompson. Practitioner, London, 1918, C, No. 2.

The value of sanatorium treatment is well established and cannot be replaced by any other methods, but it also has its limitations. Early diagnosis is of prime importance; delay in sanatorium treatment is fatal to success. The cases must be carefully selected. Those with limited lesions, only moderate constitutional disturbance, no serious complications, originally fairly good constitutions, and without history of massive or virulent infection, are suitable cases. The mentality of the patient is of great importance. Bad habits, lack of will power or intelligence are unfavorable to a cure. Experience shows that patients from a poor environment (laboring classes) respond sooner and better to treatment than those who have contracted the disease in a good milieu. Prolonged sojourn in a sanatorium is necessary; a few months' treatment is of little value.

BOOKS RECEIVED FOR REVIEW

Books received are acknowledged in this department, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for review in the interests of our readers and as space permits.

Syphilis and Public Health. By Edward B. Vedder, A.M., M.D., Lieutenant-Colonel, Medical Corps, United States Army. Published by permission of the Surgeon-General United States Army. Cloth, pp. 315, \$2.25. Lea & Febiger, Philadelphia, 1918.

A Proposed Basis for a Dietary for Hospitals for the Insane—To Meet War Conditions. By H. J. Sommer, M.D., Superintendent of Blair County Hospital for the Insane, and P. Saha, M.D., Assistant Physician, Blair County Hospital for the Insane, Professor Rea Scholar, University of Illinois College of Medicine. Printed and Distributed by Authority of the Directors of the Blair County Hospital for the Insane, Hollidaysburg, Pa., 1918.

Framingham Monograph No. 1. General Series. 1. The Program—Framingham Community Health and Tuberculosis Demonstration of the National Association for the Study and Prevention of Tuberculosis. Donald B. Armstrong, M.D., executive officer, Community Health Station, Framingham, Mass., 1918.

Emergencies of a General Practice. By Nathan Clark Morse, A.B., M.D., F.A.C.S., Surgeon to Emergency Hospital, Eldora, Iowa; District Surgeon Chicago Northwestern Railway, Minneapolis & St. Louis Railway; Ex-Vice-President Iowa State Association of Railway Surgeons; Ex-Vice-President Pan-American Congress; Fellow American Medical Association; Member of the Society of Clinical Surgeons of North America; Author of "Post-Operative Treatment." Cloth, pp. 450, 251 illustrations. C. V. Mosby Company, St. Louis, 1918.

Oral Sepsis in Its Relationship to Systemic Disease. By William W. Duke, M.D., Ph.B., Professor of Experimental Medicine in the University of Kansas School of Medicine; Professor in the Department of Medicine in Western Dental College; Visiting Physician to Christian Church Hospital; Consulting Physician to Kansas City General Hospital, Kansas City, Mo., and to St. Margaret's Hospital, Kansas City, Kansas. Cloth, pp. 124, 170 illustrations. C. V. Mosby Company, St. Louis, 1918.

The Treatment of Cavernous and Plexiform Angiomata by the Injection of Boiling Water (Wyeth Method). By Francis Reder, M.D., F.A.C.S., Visiting Surgeon to City Hospital; Consulting Surgeon to St. John's Hospital and Missouri Baptist Sanitarium, St. Louis. Cloth, pp. 75, illustrated. C. V. Mosby Company, St. Louis, 1918.

Interpretation of Dental and Maxillary Roentgenograms. By Robert H. Ivy, M.D., D.D.S., Major, Medical Reserve Corps, United States Army; Associate Surgeon Columbia Hospital, Milwaukee; Formerly Instructor in Oral Surgery, University of Pennsylvania. Cloth, pp. 146, with 259 illustrations. C. V. Mosby Company, St. Louis, 1918.

NEW INSTRUMENTS AND EQUIPMENT

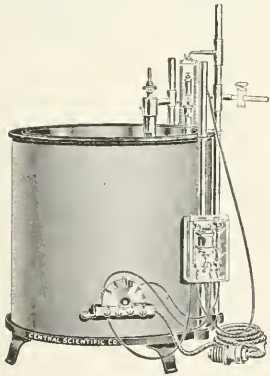
VINCENZ MUELLER, Technical Editor.
GEO. W. WALLERICH, Associate Editor.

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast avenue, Oak Park, Illinois.

Portable Water-Bath

The water-bath shown here is both electrically heated and regulated, and, therefore, a constant temperature is maintained.

The apparatus is intended for use in bacteriological, chemical, as well as physical laboratories, where constant temperature is absolutely imperative. The construction is as follows: A copper container 0.75 mm. in thickness, heavily nickel-plated inside and out, lagged with 25 mm. magnesia-asbestos (magnesia, 85 per cent) and protected outside by a sheet of Russia iron. The bath is attached to an enameled cast iron base, and supplied with nickel-



De Khotinsky electrically heated and controlled portable water bath.

plated rods to which may be attached laboratory clamps for supporting flasks, etc. Each bath is fitted with four electric heating units, three of which may conveniently be added, one by one, by means of the switch constituting a part of the bath. The fourth unit is electrically connected to the relay, which is automatically regulated by a thermoregulator.

The thermoregulator is made of a solid drawn steel tube, brass-covered and nickel-plated, filled with mercury, and has a platinum contact attached to a regulating cap, by means of which the bath can be regulated and set to any desired temperature, ranging from the temperature of the surrounding atmosphere to the boiling point of water. Should a temperature higher than the boiling point be needed, the water may be replaced by "Crisco,"

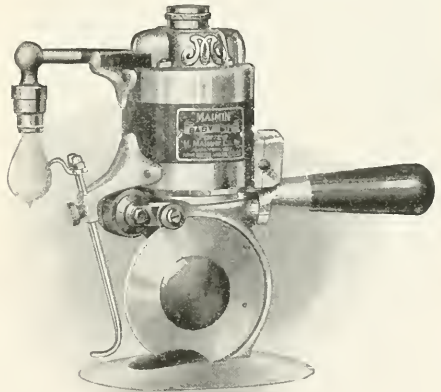
which can be used up to a temperature of 165 C., or even higher.

A constant level water attachment is also furnished with each bath, by means of which the water level can be regulated within a range of 35 mm. and maintained within one millimeter of the level at which it is set. When experiments or research demand a more vigorous circulation and regulation closer than 0.1 degree C., a small high-speed turbine type stirrer can be attached to the bath, which takes water from the bottom of the bath at the rate of five liters per minute, and delivers it at the top with an energy expenditure in the motor of 15 watts. On the shaft of the circulating turbine is an extra pulley to connect with the glass stirrer in the flask.

This apparatus is known as the De Khotinsky portable water-bath and is manufactured by the Central Scientific Company, of Chicago.

Gauze and Bandage-Cutting Machine

An electrically driven machine, similar to that used in tailor shops for cutting cloth, has recently been brought out arranged so it will cut gauze and muslin. With this machine it is possible to cut 100 yards of gauze, for use as compresses, drains, wipes, sponges, etc., in about three minutes' time. The machine cuts on the thread and all waste is eliminated. About 50 yards of muslin for wrap-



Maimin gauze and bandage cutter.

pers, head bandages, abdominal supporters, etc., can also be cut in three minutes. Many of these machines are already in use in Red Cross workshops, and it would appear that this apparatus would be of great aid, especially to the larger hospitals, where a great deal of these materials have to be used every day. This particular machine is known as the Maimin gauze and bandage cutter.

Vacuum Bottle Automatically Regulated for Suprapubic Drainage

That the establishment of satisfactory drainage of the bladder after an operation of suprapubic cystotomy has always been a most difficult problem is shown by the fact that such a great variety of drainage apparatus, some very simple, others complicated, have been devised in the past, both in this country and abroad. The condition to be met by such an apparatus is that it should not permit

any urinary leakage from the time of its application until the wound is finally healed. It is a fact that at present there is at least one such an apparatus in use which meets the above-described condition, but this device is some what expensive and as it is of the intermittent syphon type, it occasionally disturbs the rest of the patient by the noise produced from the periodical tilting of the metal water container.

Dr. E. G. Davis, of Baltimore, recently presented a new device to the profession only after it had been tried out in practice over a long period, and he states that this device, which is illustrated below, meets every requirement. The illustration will give a general idea as to the principle of the apparatus. Within the large bottle is a vacuum, which is very gradually decreased in strength by leakage of air, through a minute capillary glass tube from the smaller bottle, so that within the smaller bottle there is maintained an air pressure which is slightly less than one atmosphere. By virtue of this very slight difference in



Davis automatically regulated suprapubic drainage apparatus.

pressure, the urine is drawn out of the bladder, through the catheter and tube, and drips down into the small bottle, replacing the air which has leaked into the vacuum. The only care necessary is to empty the urine bottle when it fills, and to exhaust the air from the vacuum bottle at intervals of not less than forty-eight hours. This exhaustion can be accomplished in connection with the ordinary laboratory filter pump (which may be attached to a faucet anywhere in the hospital) in from five to ten minutes if the regular 8-liter bottle is being used.

The bottles V and U have a capacity of 8 and 2 liters, respectively. Bottle V is provided with an air-tight, four-hole rubber stopper through which pass two L-shaped pieces of glass tubing, one straight piece and one T. Bottle U has a two-hole stopper with glass tubes, as shown in the diagram. Catheter C, at the very tip of which there are several small perforations, passes into the bladder through the suprapubic wound, where it is held by strips of adhesive plaster, and is connected with the urine bottle by a rubber tube, which has a lumen not more than 5 mm. in diameter. The only means of communication between bottles U and V is through the minute capillary tube (CT) which hangs within the vacuum bottle and which makes the rate of air flow from the smaller to the larger bottle exceedingly slow. In the large bottle is also placed the small U-shaped manometer of glass tubing with a

lumen of 5 mm. which both indicates and regulates the air pressure within the urine bottles.

The advantages claimed by Dr. Davis for this apparatus are that it keeps the incision, patient, and bed clean and dry and saves a great amount of gauze and bed linen, as well as the time of doctor and nurse. It also does away with the urinary odor in the room and keeps the patient incomparably more comfortable than when ordinary methods of drainage are being employed.

Protectors for X-Ray Operators

The necessity for protection of the body, hands, and eyes of the x-ray operator and x-ray screen workers is now conceded by all who have given the matter careful consideration. The lack of such protection in days gone by caused many of the courageous pioneers in this wonderful work to lose their sight and even their lives. Two new protective glasses have recently been put on the market by F. A. Hardy & Co.—Fig. 1, under the trade name of "Noviroent," for x-ray screen workers, and Fig. 2, known as No. 303 X R, for the x-ray operator.

Concerning these protective devices, the manufacturers state that, after considerable experimentation and advice from experts, they have evolved the type of frame and shields as shown in Fig. 1 as the best adapted for the special needs of the screen worker. It affords complete protection from light, is light and easy when on the face, and

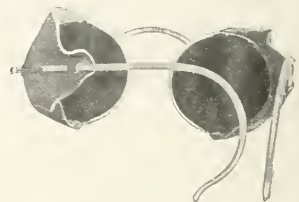


Fig. 1. Protective glasses for x-ray screen workers.



Fig. 2. Protective glasses for x-ray operators.

is easily put on and off. The temples are extra long and are covered with fiber tubing, features which insure ease and comfort to the wearer. These glasses so protect the eyes from light, when coming out of the screen room, that work can be started again immediately on returning to it. The glass used in these protectors is known as "Novi-weld" glass, which insures the needed protection, but at the same time permits the wearer clear visual acuity.

The frame of Fig. 2, the protectors for x-ray operators, is made of German silver, and the side screens are of solid silver, completely protecting the eyes from outside light. The bridge or nose-piece is easily adjustable, and may be successfully fitted to any nose, while the wide-bearing surface of the nose-rest itself guarantees freedom from disagreeable pressure. The glass used is the best obtainable lead glass, a quarter of an inch thick.

A MEETING WHICH MAY BE FRAUGHT WITH HISTORIC CONSEQUENCES

Representatives of the Hospitals of the Country Meet to Take Concerted Action on Matters of Vital Importance to All—Official Program of the Atlantic City Convention

SPECIAL BULLETIN ISSUED FROM THE EXECUTIVE OFFICES, 728 SEVENTEENTH STREET, N. W., WASHINGTON, D. C.,
HOWELL WRIGHT, EXECUTIVE SECRETARY

Plans for the Twentieth Annual Convention of the American Hospital Association are progressing favorably. The program of papers and discussion appears nearly complete on following pages, which also contain an illustrated story about Atlantic City, the playground of America, and information about opportunities to visit hospitals and institutions in Atlantic City and other parts of New Jersey and also in New York, Philadelphia and Baltimore. The local committee at Atlantic City is doing its full share in making plans to entertain the convention. A cordial welcome is extended to the association and its members by the local committee, through Dr. I. E. Leonard, chairman, and by Mr. W. F. Hanstein, manager of the Royal Palace Hotel, the convention headquarters.

ATTENDANCE AT THE CONVENTION

Every effort is being made to insure a large attendance of hospital people at this convention. A special bulletin has been mailed to trustees, governing boards and executives of American hospitals calling attention to the vital hospital issues to be decided. A special invitation has been issued to members of the Catholic Hospital Association of the United States and Canada; also to the American Dietetic Association, which holds a joint session with the American Hospital Association. Letters have been written to boards of trustees, urging them to make it financially possible for superintendents and others to attend the convention. Especial attention is called to bulletins from the war service and legislative committees appearing herewith. For the first time the president of the association has invited the governors of all the states to appoint delegates to the convention.

HOTEL HEADQUARTERS AND RESERVATIONS

The Royal Palace Hotel is headquarters for all convention activities. General sessions and section meetings, as well as the commercial and non-commercial exhibits, will be in this hotel.

Reservations should be made early and application for the same should be made to the hotel direct. Neither the office of the association nor the local committee are in a position to make reservations. The following schedule of rates for accommodations, all of which are on the American plan only, will apply to delegates to the convention and their accompanying friends:

	Per day		
One person in room without private bath....	\$ 4.00	\$ 4.50	\$ 5.00
Two persons in room without private bath....	8.00	9.00	...
One person in room with private bath.....	6.00	7.00	8.00
A few single rooms with private baths at...	5.00	...	...
Two persons in room with private bath.....	10.00	11.00	12.00

A weekly rate will be given to any one desiring to remain a week or longer upon notification. Also, a suite of two rooms with bath between, twin beds in each room, for four persons might be had for \$18.00, \$20.00 and \$22.00 per day for the party.

MAKE YOUR RESERVATIONS NOW

Many other hotels are available for convention delegates and guests at Atlantic City. A list of such hotels to-

gether with the rates will be mailed shortly to all members of the association. It is not available for publication in this bulletin.

SPECIAL ARRANGEMENTS

Special arrangements are being made for the care of the Catholic sisters who may be able to attend the con-



DR. A. B. ANCKER,
President American Hospital Association
Superintendent St. Paul City and County Hospital, St. Paul, Minn.

vention. Under date of July 29, 1918, the Sister Superior at Rita Mercy Hall, Atlantic City, writes as follows:

"I shall be pleased to help locate the sisters who shall attend said Convention. The Royal Palace Hotel is within easy walking distance as it is quite near Rita Mercy Hall . . . I shall be glad to learn from the sisters just how many I am to secure places for, so shall appreciate an early communication with the sisters. You may mention my name as you wish."

The sisters planning to attend the convention are, therefore, urged to write directly to Sister M. Carmelita, Rita Mercy Hall, 210 Grammercy Place, Atlantic City, N. J.

ENTERTAINMENT

Only reasonable plans for entertainment or social functions are being made by the association and the local committee. With the nation engaged in the serious business of making war and mobilizing all its resources for this one purpose, it would hardly be patriotic to make

elaborate expenditures for such purposes. [Buy Liberty Bonds and War Savings Stamps.]

Accordingly, entertainment features have been reduced to a minimum. As no general or section meetings are

convention for convention delegates, and an automobile ride is being planned over the boulevard to the Atlantic County Hospital for the Tuberculosis, which is about seven miles from Atlantic City. *It should be remembered*



DR. A. R. WARNER,
First Vice-President, Superintendent Lakeside Hospital, Cleveland, Ohio.



MR. E. S. GILMORE,
Second Vice-President, Superintendent Wesley Memorial Hospital, Chicago, Ill.



MR. HOWELL WRIGHT,
Executive Secretary.



MR. ASA BACON,
Treasurer, Superintendent Presbyterian Hospital, Chicago, Ill.

scheduled for Tuesday evening, it is probable that arrangements will be made by the local committee for an informal dance at the Royal Palace Hotel.

On the afternoon of the 26th there will be a life guard drill.

Local hospitals will keep open house throughout the

that merely to visit Atlantic City is to be entertained in full measure.

NON-COMMERCIAL EXHIBIT: REHABILITATION, EDUCATIONAL AND INDUSTRIAL EXHIBIT BY RED CROSS INSTITUTE

The Red Cross Institute for Crippled and Disabled Men has been developing both national and local activities.

In the national field it has established a bureau of research to collect, digest, and disseminate the best theories and practices relating to the cripples of foreign countries and has also conducted a campaign of public education in America to create a new conception of the cripple for, in the light of results already attained abroad in the training of disabled soldiers, the complete elimination of the dependent cripple has become a constructive and inspiring possibility.

In the local field the institute has started six courses of vocational reeducation and has also established an employment bureau for orthopedic cases.

The plan and scope of the cripple problem, as viewed in the experience of the Red Cross Institute, is shown in a series of twelve charts which will be exhibited at the convention, illustrating, first, the national program of rehabilitation of persons disabled in the United States

exhibit there. *Your especial attention is called to the commercial exhibitors' supplement of this, the Pre-Convention issue of THE MODERN HOSPITAL, advertising pages 68A to 68P.*

Program of Papers and Discussions

Hospital war problems will be the keynote of what is without doubt the most important meeting the American Hospital Association has ever held. The war has brought the civilian hospitals of the country face to face with serious problems. They will be discussed not only by hospital executives but by representatives of several departments of the Federal Government. The Surgeons General of the Army, the Navy and the Public Health Service have appointed representatives to take part in the program. The American Red Cross and the Federal Vocational Educational Board will also be represented.

The program has been prepared with the thought that



DR. WINFORD H. SMITH,

Trustee,

Superintendent Johns Hopkins Hospital, Baltimore, Md.



MISS MARY L. KEITH,

Trustee,

Superintendent Rochester General Hospital, Rochester, N. Y.

forces; second, various forms of occupational therapy conducted by the Surgeon General while the soldiers are confined in the convalescent hospitals; third, industrial operations possible for those physically handicapped as taught at the Red Cross Institute; fourth, the technic of placement in employment; fifth, the need of regarding the cripple from the standpoint of his capabilities rather than his disabilities.

As Douglas C. McMurtrie, director of the institute, has so truly said "There is no royal road to wisdom in dealing with the cripple. Experience is the only dependable teacher. What little of such experience the institute may have at any stage of its development will always be available to others who may come to share our enthusiasm and aim."

COMMERCIAL EXHIBIT

The executive secretary appeals to the members of this association to interest themselves in the plans for the commercial exhibit and to help the association as well as themselves by patronizing exhibitors at the convention. There are many advantages to hospital buyers in placing their orders direct with manufacturers and dealers who

hospital war problems shall not be merely discussed. *Concerted action is imperative.* Many vital hospital issues, concerning some of which there are wide differences of opinion, must be settled *now*. It is to be expected that the presence of representatives of the Federal Government will contribute to this end. The following appeal from the War Service Committee forcefully emphasizes the "issues of the day" and the duty of American hospitals to help settle them.

SPECIAL BULLETIN FROM THE WAR SERVICE COMMITTEE OF THE AMERICAN HOSPITAL ASSOCIATION

To the Trustees, Governing Boards and Executives of American Hospitals:

The great war has brought the civil hospitals of America face to face with serious problems. They can be met and solved only by concerted action. These problems will be discussed at the Twentieth Annual Convention of the American Hospital Association. Vital hospital issues must be settled at this convention. No American hospital can afford to be without representation. This convention should not be allowed to pass without demonstration of the power of the organized hospitals of America to think and to plan in terms of the present great crisis and for the future.

The civil hospitals have gladly accepted calls for war service. They have given willingly of their clinical and nursing staffs to the end that the health of our boys over here and over there shall be safeguarded.

Civil hospitals are expecting more calls for war service. The program of the convention (which is commended to your careful attention) includes reports by representatives of the army, the navy and other governmental departments, who have been asked to discuss war problems especially in their relation to civil hospitals. It is expected that they will tell the hospitals what further calls for war service will be made. The hospitals have a right to know.

The nursing program of the army and the American Red Cross will be presented and both will be discussed from the standpoint of the civil hospitals. No more important questions will be considered at the convention. There are wide differences of opinion as to the relative merits of the various war nursing programs. Civil hospitals and their civilian clientele are vitally concerned.

The war service committee in a special bulletin has already pointed out your responsibility for simplifying staff service, so that all the men who can be spared are released for Army service.

The legislative committee has already communicated with you about hospitals and the inheritance tax.

The war service committee appeals to the hospitals of America to

of the nation at war." We look to Dr. Arthur B. Ancker, pioneer in the municipal hospital service of this country, to emphasize the importance of hospital standardization *by the hospitals themselves*. He will advocate the adoption of the proposed plan for institutional membership that the association may develop along broader lines.

The report of the special committee on institutional membership, which will be read by the chairman, Dr. A. R. Warner, will have important bearing upon the future of the association. It is printed in full, following the program of the meeting, and should be read by all those interested in the future of the association.

SECTION MEETINGS

This year, for the first time, the program has been divided into general session and section meetings. The



Boardwalk scene, Easter Sunday, Atlantic City

send representatives to this convention and to boards of trustees to make it financially possible for these representatives to attend.

THE AMERICAN HOSPITAL ASSOCIATION,
By its WAR SERVICE COMMITTEE,
DR. S. S. GOLDWATER, Chairman.
DANIEL D. TEST,
DR. A. R. WARNER,
DR. WM. A. WHITE,
RICHARD P. BORDEN, Secretary.

OPENING SESSION

The convention will open Tuesday morning, September 24, at 9 o'clock with an invocation by Rev. Thomas J. Cross of Atlantic City. This will be followed by an address of welcome by the Hon Walter E. Edge, governor of New Jersey.

The president's address is anticipated with considerable interest. As of first importance, it will, of course, deal with the hospital problems of today which "are not alone individual problems but the hospital and health problems

following sections have been approved by the trustees: nursing; social service; out-patient work; hospital administration; hospital construction; dietetics. Each section will hold two section meetings and will have one paper at a general session of the convention. The chairmen of the sections have arranged the section meeting programs. So far as possible, especial attention has been given to war-time hospital and dispensary topics. This experiment of section meetings will be watched with great interest. Tuesday, Thursday and Friday afternoons, the 24th, 26th and 27th, are devoted exclusively to section meetings. The titles and authors of the sectional papers and discussions will be found in the official program as printed on a following page.

WEDNESDAY, SEPTEMBER 25

Wednesday is devoted entirely to the consideration of hospital problems resulting from the war.

Morning—A report of the war service committee will

be read by Mr. Richard P. Borden, secretary of the committee, and a trustee of the association. The American Hospital Association owes a great debt to Mr. Borden. As secretary of the war service committee he has given much time and thought to the war activities of the association. At his own expense he has spent at least three days a week in Washington since his appointment as secretary of the committee. He is, therefore, familiar with the work of the Surgeon General's office and the Council of National Defense and their programs for handling various hospital and medical educational problems. It is due to the efforts of the war service committee, and particularly to those of its secretary, that the influence of the American Hospital Association has been felt in Washington. Mr. Borden's report will be timely and contain first-hand information. Col. Winford H. Smith, a trustee of the association, has been appointed as the representa-

"Social Considerations in the Rehabilitation of the Disabled," will be discussed by Mr. Douglas C. McMurtrie, director of the Red Cross Institute for Crippled and Disabled Men. He will be followed by Mr. T. B. Kidner, vocational secretary of the Invalided Soldiers' Commission of Canada. With the aid of motion pictures he will tell about Canada's wonderful reconstruction work. Canada's experience, as told by Mr. Kidner, will set forth many helpful lessons to American hospitals.

Evening—Miss Georgia M. Nevins, chairman of the section on nursing, has arranged an unusually attractive nursing program for Wednesday evening. The nursing program of the army and of the American Red Cross will be discussed by Miss Annie W. Goodrich, dean of the Army School of Nursing, who has been designated to represent the Surgeon General of the Army, and by Miss Jane A. Delano, director of the department of nurs-



Steel Pier, Atlantic City

tive of the Surgeon General of the Army and will speak to the association about the hospital and medical education programs of the Surgeon General's office. Colonel Smith will, of course, be prepared to answer questions relative to the rapidly diminishing supply of interns and medical students, as well as questions pertaining to the use of civilian hospitals by the Surgeon General's department for the care of soldiers. The navy will be represented on this occasion, and the association will have an opportunity to learn to what extent the navy is using, or expects to use, civilian hospitals. The Surgeon General of the Navy has designated Arthur W. Dunbar, Medical Director of the Navy, to represent him and address himself to this subject. Colonel Robert L. Dickinson, medical adviser to the General Staff of the Army, will be present at this session.

Afternoon—Reconstruction and rehabilitation problems will furnish the topics for this session, which will be most interesting and profitable. Mr. C. A. Prosser, director of the Federal Board for Vocation Education, will tell the association about the work of this new Federal department and what it expects of the civilian hospitals in its rehabilitation program.

ing, American Red Cross. These programs from the standpoint of civil hospital administration will be discussed by Miss Adelaide Nutting, Teachers' College, Columbia University, and by leading hospital executives. Advocates of the Army School of Nursing as well as of the "nurses' aid" plan as a means of meeting the present "nursing crisis" will no doubt express themselves. This program should provoke wide discussion.

THURSDAY, SEPTEMBER 26

At the general session on Thursday morning Mr. Michael M. Davis, Jr., chairman, will make a report for the committee on out-patient work, which will be followed by two other important papers on dispensary war service in this country and in France. Mr. Davis is well known to the association as a leader in medical social service work and can be counted upon to present an effective program. Mr. N. V. Perry, constructing engineer, United States Public Health Service, will give an illustrated talk on "Hospital Construction."

FRIDAY, SEPTEMBER 27

On Friday morning the section on hospital administration will be represented at the general session by Mr.

A. B. Tipping, superintendent of the Touro Infirmary, Louisiana. He will speak on "Extension of Civil Hospitals for Military Emergencies." This will be followed by the report of the legislative committee. This report will include some reference to the incorporation of the American Hospital Association; hospitals and the Federal inheritance tax; and certain legislative aspects of sickness and health insurance.

The following bulletin, which has been widely distributed, makes plain the necessity of concerted legislative action on the part of this association in support of the Rainey bill to protect the financial future of American hospitals.

728 Seventeenth Street, Washington, D. C.

August 8, 1918.

To the Trustees, Governing Boards and Executives of American Hospitals:

You are interested in the financial future of hospitals. The Legis-

has been guaranteed by further bequests to be used as endowment funds.

A large proportion of these bequests was from large estates and most frequently was of residues after the immediate family of the testator were, in his estimation, sufficiently provided for.

It is the duty of the testator first to make proper provision for his wife and children and for others of his immediate family for whom he feels responsibility. It is customary, therefore, to make specific provision of adequate amounts for such dependents, and thereafter bequeath the residue or balance to charitable uses. To secure this the testator frequently provides that the specific bequest to dependents shall not be diminished by inheritance taxes, but that all inheritance taxes shall be paid from the residue.

Take, for example, an estate of \$1,000,000 and suppose that the testator determines that \$900,000 shall be given to his immediate family; leaving a residue of \$100,000 to be given to a hospital. Today this residue must be diminished by both the state and federal inheritance taxes. Although, in most of the states, bequests to charitable purposes are free from taxation, this cannot prevent the reduction of the residue by other inheritance taxes if it be provided that such taxes be paid therefrom. In this estate, therefore, the residue will be dimin-



Atlantic City headquarters of the American Hospital Association, Royal Palace Hotel

lative Committee of the American Hospital Association solicits your cooperation and urges you to appeal at once to your representatives in Congress to see that adequate legislation is provided to remedy a very serious menace. The following statement will explain it in full. Please urge them to support the bill (H. R. 9223) by Mr. Rainey. Please notify Howell Wright, Chairman Legislative Committee, 728 Seventeenth Street, Washington, what reply you receive from your representative.

HOSPITALS AND THE FEDERAL INHERITANCE TAX

A bill (H. R. 9223) has been introduced in Congress by Mr. Rainey and referred to the committee on ways and means, the principle of which is to relieve charitable institutions, including hospitals not operated for private gain, from the unjust burden created by the new inheritance tax law. This bill should have the earnest support of all hospital authorities.

The Federal Inheritance Tax Law is far more dangerous in its effect upon hospital bequests than it appears to be on a casual reading.

Unlike most of all state laws, the tax is imposed upon the net estate of the decedent after deducting from the gross estate certain stipulated debts and expenditures; it increases with the size of the estate.

According to the census report of 1910, there was then invested in benevolent institutions \$643,000,000 with an annual expenditure of \$111,000,000, and of this amount \$66,000,000 was invested in hospitals and sanatoria. These amounts have been tremendously increased since the census report, and as is well known, many of our larger hospitals were instituted or made possible by bequests; after which maintenance

ished by some \$80,000 on account of the federal tax, and the balance would disappear by reason of the state inheritance taxes. Previous to the inheritance tax laws the hospital might anticipate the receipt of \$100,000; today it would receive nothing.

Taxation upon inheritances is just and reasonable. Charitable institutions must inevitably suffer, therefore, but to make such institutions bear the major part of the burden is unjust and unreasonable and legislative action should be invoked to bring the law within the boundaries of justice and reason.

Hospitals must exist. Heretofore they have existed largely on account of private benevolence. If this source of revenue is stopped by prohibitive laws the burden must inevitably be borne by taxation and nothing is saved, but much loss caused, by stifling charitable impulse and interest and placing the burden of hospital support upon the public tax gatherer.

AMERICAN HOSPITAL ASSOCIATION,
By its LEGISLATIVE COMMITTEE,
HOWELL WRIGHT, Chairman.
OLIVER BARTINE,
DR. GEO. O'HANLON.

HOSPITALS AND HEALTH INSURANCE

Hospitals are vitally concerned with sickness and health insurance programs. The subject is now being studied by several state commissions. There can be no comprehensive system for sickness insurance without hospitals. If such a system is adopted, it must involve the building of new

hospitals or the use of existing ones. The basis for compensation for hospital service rendered to those protected by health insurance laws is important. What basis shall be universally adopted? Hospitals must be consulted in the preparation of health insurance schedules of payments for hospital and dispensary service. It can not be left entirely to legislatures and state boards, as has been done under workmen's compensation acts. The report will urge legislative action along these lines by the association. Invitations have been issued to the members and officials of the health insurance commissions in the states of Pennsylvania, California, Illinois, Connecticut, Wisconsin, New Jersey, Ohio, who, it is hoped, will send repre-

help to conserve the food supplies of the nation. Dr. Lafayette B. Mendel of Yale University will speak of the status of the dietitian in the hospital. Miss Lulu G. Graves, editor of the Department of Dietetics of THE MODERN HOSPITAL, formerly dietitian at Lakeside Hospital, Cleveland, will tell the convention how the dietary department of the hospital should be managed in the interests of health and conservation. Leading hospital superintendents will be called upon to discuss these papers.

SATURDAY, SEPTEMBER 28

On Saturday morning Mr. Cornelius S. Loder will report for the committee on accounting. This will be fol-



Hotel Chalfonte and Boardwalk scene

sentatives to attend and take part in the discussion.

Continuing this program, Mr. Royal Meeker, United States Commissioner of Labor Statistics, will address himself to the subject "Hospitals and Health Insurance." He is an authority on health insurance, and the association will be fortunate indeed in his presence at the convention. The discussion will be opened by Dr. Thomas Howell, chairman of the committee on social insurance of the association. Plans are being made to hold a conference of directors of health insurance commissions from the several states at Atlantic City.

FRIDAY EVENING, SEPTEMBER 27

One of the features of the convention will be the joint general session of the American Hospital Association and the American Dietetic Association. Hospitals as well as individuals are expected to conserve food. "Food will win the war." On Friday evening hospital executives may expect the dietitians to tell them how they can further

be helped by other committee reports, including the time and place committee and the election of officers for the ensuing year.

MEETING OF REPRESENTATIVES OF EPISCOPAL HOSPITALS

At the Cleveland, 1917, convention a group of delegates representing hospitals of the Episcopal church met and considered some of their mutual problems. A committee which was appointed to consult with the different church hospitals during the past year has had several meetings.

Arrangements are being made for a meeting of this group at the convention of the American Hospital Association at Atlantic City. A questionnaire has been prepared by the committee and sent to all the Episcopal hospitals to be represented in the proposed conference. It is expected that a number of institutions will be represented. Meetings of this conference will be open to delegates to the convention. A program of papers and discussions will be arranged. The acting secretary of this conference is

Rev. Frank R. Jones, chaplain of Willard Parker Hospital, foot of East Sixteenth Street, New York City.

Convention Calendar

Monday, September 23, 1918.

3 p. m.: Registration.

Tuesday, September 24, 1918.

9 a. m.: General session.

2 p. m.: Section meetings.

1. Out-patient work.

2. Nursing.

3. Social service.

4. Hospital construction.

Evening: Entertainment.

Wednesday, September 25, 1918: Hospital Problems Resulting from the War.

9 a. m.: General session: Hospitals and Medical Education.

2 p. m.: General session: Reconstruction and Rehabilitation.

8 p. m.: General session: Nursing.

Report of the Secretary, including Membership and Publicity Committee Reports—Howell Wright, Cleveland.

Announcements—Appointment of Committee on Time and Place.

Inspection of commercial and non-commercial exhibits.

AFTERNOON, 2 P. M.: SECTION MEETINGS.

Section on Out-patient Work—Michael M. Davis, Jr., Boston, chairman.

Fighting Venereal Disease: A National Program Calling for Dispensary Service. Speakers to be arranged in cooperation with the office of the Surgeon General and of the United States Public Health Service (lantern slide illustrations probably to be included).

Section on Nursing—Miss Georgia M. Nevins, director Nursing Bureau, Potomac Division, American Red Cross, Washington, chairman. Program to be announced.

Section on Social Service—John E. Ransom, superintendent Central Free Dispensary, Chicago, chairman.

Relation of Social Service to the Successful Treatment of Gonorrhea and Syphilis in Hospitals and Dispensaries, Miss Ida M. Cannon, chief of social service, Massachusetts General Hospital, Boston.



Hotels Dennis, Marlboro-Blenheim, and Traymore

Thursday, September 26, 1918.

9 a. m.: General session.

2 p. m.: Section meetings.

1. Out-patient.

2. Dietetics.

3. Social service.

4. Hospital administration.

Friday, September 27, 1918.

9 a. m.: General session.

2 p. m.: Section meetings.

1. Hospital administration.

2. Dietetics.

3. Hospital construction.

4. Nursing.

8 p. m.: Joint general session: American Hospital Association and American Dietetic Association.

Saturday, September 28, 1918.

9 a. m.: General session: Reports of committees, election of officers, adjournment.

Official Program of the Convention

TUESDAY, SEPTEMBER 24, 1918

MORNING, 9 A. M.: GENERAL SESSION.

Invocation—Rev. Thos. J. Cross.

Address of Welcome—Hon. Walter E. Edge, governor of New Jersey, or his representative.

President's Address—Arthur B. Ancker, M.D., St. Paul.

Report of Special Committee on Institutional Membership in the Association—A. R. Warner, M.D., Cleveland.

A Social Worker at the Admission Desk, Miss Janet Thornton, registrar, Boston Dispensary, Boston.

Section on Hospital Construction—George O'Hanlon, M.D., New York, chairman.

Program to be announced.

Inspection of exhibits.

EVENING

Entertainment by local committee.

WEDNESDAY, SEPTEMBER 25, 1918

MORNING, 9 A. M.: GENERAL SESSION

HOSPITAL PROBLEMS RESULTING FROM THE WAR

Hospitals and Medical Education

Report of War Service Committee—Richard P. Borden, Fall River, Mass., secretary.

General Problems of Medical Education, the Training of Interns and the Supply of Interns to Civil Hospitals as Related to the Program of the Surgeon General of the Army, Col. Winford H. Smith. (Colonel Smith will represent the Surgeon General's office and will be prepared to discuss "The Hospital Program of the Medical Department.") Col. R. L. Dickinson, medical adviser to the General Staff of the Army, will be present at this session.

Utilization of Civil Hospital Facilities by the Navy, Arthur W. Dunbar, medical director United States Navy.

Public Health Nursing and the War—Miss Mary Beard, president National Organization for Public Health Nursing.

AFTERNOON, 2 P. M.: CONTINUATION OF WAR SERVICE PROGRAM

Reconstruction and Rehabilitation

Federal Vocational Board and the Civil Hospitals, C. A. Prosser, director of the Federal Board for Vocational Education.

Social Considerations in the Rehabilitation of the Disabled, Douglas C. McMurtrie, director, Red Cross Institute for Crippled and Disabled Men.

Canada's Rehabilitation and Reconstruction Work (illustrated by motion pictures), T. B. Kidner, vocational secretary of the Invalided Soldiers Commission of Canada.

Inspection of exhibits.

EVENING, 8 P. M.: CONTINUATION OF WAR SERVICE PROGRAM
Nursing

Miss Georgia M. Nevins, chairman of the section on nursing, presiding. The Nursing Program of the Army, Miss Annie Goodrich, dean of the Army School of Nursing (representing the Surgeon General of the Army).

The Nursing Program of the American Red Cross, Miss Jane A. Delano, director Department of Nursing, American Red Cross.

Problems and Opportunities in Out-patient Obstetrical Work or the Problem of the Cardiac.

Section on Hospital Administration—Joseph B. Howland, M.D., Boston, chairman.

Description of Clinical Record System at the Presbyterian Hospital—Adrian Lambert, M.D., Presbyterian Hospital.

Two Time-Savers, L. H. Burlingham, M.D., superintendent Barnes Hospital.

Inspection of exhibits.

FRIDAY, SEPTEMBER 27, 1918

MORNING, 9 A. M.: GENERAL SESSION

Extension of Civil Hospitals for Military Emergencies—A. B. Tipping, superintendent Toussaint Infirmary, New Orleans, La. Discussion.

Report of Legislative Committee—Howell Wright, Cleveland.



Inlet Palm Garden

The Nursing Programs of the Army and American Red Cross from the Standpoint of Civil Hospital Administration, Miss Adelaide Nutting, Teachers' College, Columbia University.

Discussion.

THURSDAY, SEPTEMBER 26, 1918

MORNING, 9 A. M.: GENERAL SESSION

Report of Committee on Out-Patient Work—Michael M. Davis, Jr., Boston, chairman.

Paper on Development of War Service.

Dispensaries in France under American auspices, by a medical staff member of the American Red Cross.

Hospital Construction (illustrated)—N. V. Perry, Constructing Engineer United States Public Health Service.

AFTERNOON, 2 P. M.: SECTION MEETINGS

Section on Out-patient Work—Michael M. Davis, Jr., Boston, chairman.

Papers and discussions on: Raising Money for Dispensaries During the War; Dealing with Food Problems Among Dispensary Patients; Industrial Dispensaries as Part of a Program for National Efficiency During the War.

Section on Dietetics (meeting of American Dietetic Association)—Miss Lulu Graves, Chicago, chairman.

The Dietitian in Cooperation with the Red Cross, Miss Edna White, professor home economics, Ohio State University, Columbus, Ohio. City Dietary Survey, Miss Lucy Gillette, director Dietetic Bureau, Boston.

Section on Social Service—John E. Ransom, Chicago, chairman.

The Aims of Hospital Social Service.
Training for Medical Social Service.

Hospitals and Health Insurance—Royal Meeker, United States Commissioner of Labor Statistics.

Discussion led by Dr. Thomas Howell, New York, chairman committee on social insurance of the American Hospital Association.

Social Service and Hospital Efficiency—A. R. Warner, M.D., Cleveland Discussion.

AFTERNOON, 2 P. M.: SECTION MEETINGS

Section on Hospital Administration—Joseph B. Howland, M.D., Boston, chairman.

War Time Economies—T. A. Devan, M.D., assistant superintendent Peter Bent Brigham Hospital.

Hospital Interns—Dr. Harold W. Hersey, assistant resident physician, Massachusetts General Hospital.

Section on Dietetics—Lulu Graves, Chicago, chairman.

Dietary Calculations—Miss Caroline Hunt.

Food Poisoning—Dr. C. E. A. Winslow, professor public health, Yale University.

Industrial Dietetics—Miss Freeman.

Section on Hospital Construction—George O'Hanlon, M.D., New York. Program to be announced.

Section on Nursing—

Program to be announced.

Inspection of exhibits.

EVENING, 8 P. M.: JOINT GENERAL SESSION, AMERICAN HOSPITAL

ASSOCIATION AND AMERICAN DIETETIC ASSOCIATION

The Status of the Dietitian—Dr. Lafayette B. Mendel, Yale University. The Management of the Dietary Department of the Hospital—Miss

Lulu G. Graves, Editor Department of Dietetics, THE MODERN HOSPITAL.
Discussion.

SATURDAY, SEPTEMBER 28, 1918

MORNING, 9 A. M.: GENERAL SESSION

Report of Treasurer—Asa S. Bacon, Chicago.

Report of Auditing Committee—W. E. Woodbury, M. D., New York, Chairman.

Report, Committee on Accounting—Cornelius S. Loder, New York.

Report, Committee on Time and Place.

Election of Officers.

Adjournment.

Report of the Special Committee to Consider Institutional Membership in the American Hospital Association

At a meeting of the trustees held in Washington June 12, 1918, a resolution was passed authorizing the president to appoint a committee to consider the question of so changing the American Hospital Association as to make it an association of hospitals and other public health institutions instead of a purely voluntary personal association of hospital people. Under this resolution the

standardization from election to membership. It is hoped that the association will promptly undertake more far-reaching and complete work along these lines.

The following copies of the constitution and bylaws of the American Hospital Association, showing by parentheses and underlining the parts omitted and by capitals the parts added, is reported and recommended to the committee on constitution and by-laws and to the association.

A. R. WARNER, Chairman.
RICHARD P. BORDEN.
MICHAEL M. DAVIS, JR.

CONSTITUTION

Proposed parts printed in capitals. Parts stricken out in parentheses and italics.

ARTICLE I

The name of this Association shall be "The American Hospital Association."

ARTICLE II

The object of this Association shall be, to promote the welfare of the people so far as it may be done by the institution, care and man-



Country Club, Northfield, seven miles from Atlantic City

undersigned committee was appointed and makes the following report:

There is in the opinion of the committee a need for an association of American hospitals to promote the welfare of American hospitals, develop their efficiency, enlarge their field of usefulness and correlate it with other forms of public health and social work and at all times to protect the interests of hospitals and hospital work. Corresponding associations have been formed by various commercial interests with uniform success. There seems to be no fundamental reason why an association of hospitals would not be equally successful.

In order to provide for the organization of a strong, efficient association of American hospitals and in order to make it possible for and encourage this association to become at once active in developing the common interests and in order that the association should be alive and active every day of the year, numerous changes in the constitution and by-laws seem necessary.

It is the hope of the committee that this change in the American Hospital Association shall be the first step in the standardization and classification of hospitals by this association. Although this standardization and classification seems particularly a task of the American Hospital Association, it has not been thought advisable to attempt this in the constitution beyond the simple, yet effective

agement of hospitals and dispensaries with efficiency and economy, to aid in procuring the cooperation of all organizations with aims and objects similar to those of this Association; and in general, to do all things which may best promote hospital efficiency.

ARTICLE III

(Section 1. The membership of this Association shall be active, associate and honorary. The active and associate members may become life members in their respective classes upon the payment of \$50 for active and \$25 for associate membership.)

SECTION I. THE MEMBERSHIP OF THIS ASSOCIATION SHALL BE—

A. INSTITUTIONAL.

ANY CORPORATION OR ASSOCIATION ORGANIZED FOR THE PROMOTION OF PUBLIC HEALTH OR FOR THE CARE OR TREATMENT OF THE SICK OR INJURED SHALL BE ENTITLED TO MEMBERSHIP SUBJECT TO THE FOLLOWING:

APPLICATIONS FOR INSTITUTIONAL MEMBERSHIP SHALL BE ADDRESSED TO THE EXECUTIVE SECRETARY IN WRITING, SIGNED BY A DULY AUTHORIZED REPRESENTATIVE OF THE CORPORATION OR ASSOCIATION; THEY SHALL BE REFERRED TO THE MEMBERSHIP COMMITTEE AND THE APPLICANT SHALL BECOME A MEMBER UPON RECEIVING THE APPROVAL OF THE MAJORITY OF THE MEMBERSHIP COMMITTEE AND UPON THE PAYMENT OF THE INITIATION FEES AS FOLLOWS: HOSPITALS WITH A CAPACITY OF LESS THAN 100 BEDS SHALL PAY TEN DOLLARS; THOSE FROM

100-250 BEDS, INCLUSIVE, SHALL PAY TWENTY DOLLARS; ALL OVER 250 BEDS SHALL PAY THIRTY DOLLARS; ALL OTHER ORGANIZATIONS ELIGIBLE TO MEMBERSHIP SHALL PAY TEN DOLLARS.

CONSTITUTIONAL INSTITUTIONAL MEMBERS SHALL BE ENTITLED TO APPOINT AS THEIR REPRESENTATIVES IN THE ASSOCIATION ANY PERSON OR PERSONS WHO ARE ELIGIBLE TO ACTIVE OR ASSOCIATE MEMBERSHIP IN THE ASSOCIATION, AND OF THE NUMBER SO APPOINTED NO MORE THAN THREE, INCLUDING THE SUPERINTENDENT, SHALL HAVE ALL THE PRIVILEGES AND AUTHORITY OF ACTIVE PERSONAL MEMBERS AND SHALL BE SO DESIGNATED, AND OTHERS SO APPOINTED SHALL HAVE THE PRIVILEGES OF ASSOCIATE PERSONAL MEMBERS.

B. PERSONAL.

Active PERSONAL members shall be those who at the time of their election are trustees or superintendents, or assistant superintendents, of hospitals, or members of the medical staffs of hospitals,

Section (5) 3. Honorary PERSONAL membership AFTER APPROVAL OF THE MEMBERSHIP COMMITTEE may be suggested at any session of the Association by any member for any person who by reason of public or private service, or for any other reason, should be entitled to such recognition; and such person may be elected an honorary PERSONAL member by a majority vote of those present at any subsequent session of the Association.

Honorary PERSONAL members shall have all the privileges of active PERSONAL members, except voting at meetings of the Association. They shall be exempt from the payment of dues.

ARTICLE IV OFFICES

Section 1. The officers of the Association shall be a President, three Vice-Presidents, an EXECUTIVE Secretary, a Treasurer, and a Board of Trustees as hereinbefore provided.

The EXECUTIVE Secretary shall serve as Secretary of the Board of Trustees.

Section 2. The above officers, other than the Board of Trustees,



Bathing scene taken from Steel Pier. Garden Pier in background at right

however such officials may be designated. Any person once an active PERSONAL member may continue such membership so long as the rules of the Association are conformed with.

Associate PERSONAL members shall, at the time of their election, be heads of any executive, administrative, or educational department of a hospital, other than as designated in Section 2, or contributors to, or members of, any association or board, the object of which is the foundation, maintenance or improvement of hospitals or the promotion of organized charities for the improvement of health. Associate PERSONAL members may hold office, but shall not have the right to vote at meetings of the Association.

Applications for active or associate PERSONAL membership shall be in writing, addressed to the EXECUTIVE Secretary, and shall be endorsed by one or more members of the Association. They shall be referred to the Committee on Membership; and the applicant shall become a member upon receiving the approval of a majority of said Committee, and upon payment of an initiation fee of five dollars for active and two dollars for associate membership, which shall cover the dues payable at the next convention of the Association after election.

SECTION 2. Upon attaining any of the offices designated in Section 2 an associate PERSONAL member may become an active PERSONAL member by (the payment of three dollars) COMPLETING THE PAYMENT OF THE DUES FOR ACTIVE PERSONAL MEMBERS AS PROVIDED IN THE BY-LAWS.

shall be elected at each convention, shall assume their duties at the close of the convention, and shall serve until the close of the convention next succeeding, or until their successors are regularly elected and installed.

ARTICLE V TRUSTEES

There shall be a Board of five Trustees, which shall have charge of the property and financial affairs of the Association, and shall hold title thereto under the name of "Trustees of the American Hospital Association." The President and Treasurer shall constitute two of said Trustees, and one Trustee shall be elected annually, at the convention, to serve for three years, excepting that in 1916; one of said Trustees shall be elected for one year, one for two years, and one for three years. Trustees shall serve until their successors are elected.

The Board of Trustees shall, always subject to the vote of the Association, have general control and management of the business of the Association, and may appoint and fix the salaries of such officers and agents as it may deem necessary and expedient and establish rules and rates for the use of such facilities as it may in its judgment provide. (They shall make an annual report to this Association.)

ARTICLE VI SECTIONS

In order to facilitate the work of the Association, sections may be formed and discontinued from time to time, as the Trustees may by

vote determine. Such sections may be geographic, in order that recognized meetings of the Association may be held in various parts in places not easily accessible to all members, or may be departmental in their nature and devoted to any recognized branch of hospital work. Proceedings of any authorized section of the Association approved by the Board of Trustees may become a part of the proceedings of the Association, and any resolution adopted by a geographic section shall be recognized as a motion duly made and seconded by any general session of the Association, and vote of the general Association shall be taken thereon.

ARTICLE VII ANNUAL DUES

In order to provide funds for the maintenance of the Association, BOTH INSTITUTIONAL AND PERSONAL members shall pay annual dues as may be determined by the By-Laws.

ARTICLE VIII

(All vacancies in office and in the Board of Trustees shall be filled by vote of the Board of Trustees.) ANY VACANCIES OCCURRING BETWEEN THE REGULAR ANNUAL MEETINGS IN THE OFFICE OF THE PRESIDENT, THE VARIOUS VICE-PRESI-

his absence, by a Vice-President, upon the written petition of not fewer than ten (10) members. This petition shall recite the object of the meeting. The President, through the Secretary, shall give notice of not less than sixty (60) days before the proposed time of such special meeting to each member of the Association, which notice shall also recite the object of the meeting.

Section 3. A quorum of the Association shall consist of not fewer than thirty (30) VOTING DELEGATES or active members.

Section 4. Meetings of sections shall be held in accordance with the rules established by the enrolled members of the section hereinafter provided; provided, however, that such meetings shall not interfere with any general session of the Association.

ARTICLE II ELECTIONS

Section 1. All officers shall be elected by ballot, excepting where it is otherwise ordered.

Section 2. A majority of the votes cast shall constitute an election.

Section 3. (Only active members shall be entitled to vote) ONLY THE DELEGATES OF THE CONSTITUENT INSTITUTIONAL MEMBERS SO AUTHORIZED BY ARTICLE III, SECTION 1, AND



Atlantic City Hospital

DENTS, TREASURER, EXECUTIVE SECRETARY OR BOARD OF TRUSTEES, SHALL BE FILLED TEMPORARILY BY VOTE OF THE BOARD OF TRUSTEES; ANY OTHER VACANCIES SHALL BE FILLED TEMPORARILY BY APPOINTMENT OF THE PRESIDENT; AND SHALL HOLD OFFICE UNTIL THEIR SUCCESSORS ARE ELECTED BY THE ASSOCIATION.

ARTICLE IX AMENDMENTS

The Constitution and By-Laws may be amended by vote of not less than two-thirds of the members present and voting at a recognized general session of the Association; provided, however, that proposed amendments shall be submitted in writing at a recognized, general session, and shall not be acted upon at the session at which they are proposed, but may be at any subsequent session.

BY-LAWS

Proposed parts printed in capitals. Parts stricken out in parentheses and italics.

ARTICLE I

Section 1. There shall be an annual meeting or convention of the Association, held at a time and place fixed by vote of the Association, or, if not so determined, by the Board of Trustees. (The Committee on Local Arrangements shall, in conjunction with) The President and the EXECUTIVE Secretary SHALL arrange programs for the convention.

Section 2. Special meetings may be called by the President, or in

ACTIVE PERSONAL MEMBERS SHALL BE ENTITLED TO VOTE.

ARTICLE III DUTIES OF OFFICERS

Section 1. The President shall preside at all meetings of the Association, AND OF THE BOARD OF TRUSTEES, OF WHICH HE SHALL BE THE CHAIRMAN. He shall appoint all committees, unless, by vote of the Association, other provisions shall be made. He shall be, ex officio, a member of all standing and special committees.

Section 2. The Vice-Presidents shall, in the order of their rank, in the absence of the President, perform his duties.

(Section 3. The Secretary shall keep the minutes of the meetings and records of the Association in books provided for these purposes. The Secretary shall furnish to the Committee on Publication within ten days after the adjournment of the regular convention, a correct copy of the minutes thereof for publication in the "Proceedings.")

(Section 4. The Secretary shall conduct the correspondence of the Association, and shall keep on file all letters and correspondence, together with all the replies thereto, and perform such other duties that may be required of him by the Trustees.)

Sections 3 and 4 combined to read as follows: SECTION 3. SUBJECT TO INSTRUCTIONS FROM THE ASSOCIATION OR FROM THE BOARD OF TRUSTEES, THE EXECUTIVE SECRETARY SHALL BE THE GENERAL EXECUTIVE OFFICER OF THE ASSOCIATION WITH DUTIES, RESPONSIBILITIES AND PRIVILEGES SUCH AS GENERALLY ACCOMPANY SUCH EXECUTIVE

POSITIONS. HE SHALL KEEP THE MINUTES OF THE MEETINGS AND THE RECORDS OF THE ASSOCIATION IN BOOKS PROVIDED FOR THESE PURPOSES. SUBJECT TO THE ORDER OF THE TRUSTEES, HE MAY SERVE AS SECRETARY OF STANDING COMMITTEES, EXCEPT THE COMMITTEE ON THE NOMINATION OF OFFICERS, AND PERFORM SUCH OTHER DUTIES AS THE ASSOCIATION AND THE BOARD OF TRUSTEES SHALL DIRECT. UNDER THE DIRECTION OF THE TRUSTEES THE EXECUTIVE SECRETARY SHALL REPORT TO THE ASSOCIATION THE PROCEEDINGS OF THE TRUSTEES AND ALSO MAKE SUCH REPORT OF HIS OWN SERVICES AS MAY BE ADVISABLE.

Section (5) 4. The Treasurer shall receive all dues and other moneys of the Association and shall deposit and account for same, under the direction and control of the Board of Trustees. He shall give to said Board such bond as it shall determine for the faithful performance of his trust. Such bond shall be in the custody of the

tees as VACANCIES EXIST. The action of this Committee is at all times subject to the approval of the convention.

Section 3. (The Membership Committee shall receive, consider and act upon candidates for membership, and shall report results to the convention.)

THE MEMBERS OF THE MEMBERSHIP COMMITTEE SHALL CONSIDER ALL APPLICATIONS FOR MEMBERSHIP, DETERMINE THE ELIGIBILITY OF THE APPLICANT AND EXPRESS THEIR APPROVAL OR DISAPPROVAL THEREOF TO THE EXECUTIVE SECRETARY.

Section 4. The Committee on Constitution and Rules shall consider and report on all proposed amendments in the Constitution and By-Laws and all Rules of Order.

Section 5. The President shall have the power to appoint such special Committees as may be deemed desirable.

(There shall be a Standing Committee on Out-Patient work, to consist of three members appointed by the President. The terms of



Dr. I. E. Leonard's Sanitarium, Atlantic City.

President. All disbursements and expenditures shall be made under the direction of the Board of Trustees and subject to its rules and requirements. The Treasurer shall keep proper books of account, and shall present a report of the finances of the Association at the annual meeting.

ARTICLE IV

Section 1. The President shall, immediately after his election, appoint a committee on Local Arrangements to consist of the President AND EXECUTIVE SECRETARY *ex officio* (not less than four additional members) AND SUCH ADDITIONAL PERSONS AS HE MAY DEEM ADVISABLE AND ALSO the following standing committees of three members each; namely, A Committee on Constitution and Rules, a Committee on Nomination of Officers, (A Committee on Development of the Association) a Legislative Committee, A MEMBERSHIP COMMITTEE, and (Publication Committee, composed only of active members) a COMMITTEE ON TIME AND PLACE OF NEXT MEETING, COMPOSED OF DELEGATES OR ACTIVE MEMBERS AND THE PRESIDENT SHALL ALSO APPOINT A STANDING COMMITTEE ON OUT-PATIENT WORK TO CONSIST OF THREE MEMBERS APPOINTED BY THE PRESIDENT. THE TERMS OF OFFICE AT THE FIRST APPOINTMENT SHALL BE SO ADJUSTED THAT ONE MEMBER SHALL GO OUT OF OFFICE ANNUALLY. THIS COMMITTEE SHALL UNDERTAKE SUCH STUDY OR ACTIVITY AS MAY ADVANCE PROGRESS OF OUT-PATIENT SERVICE AND SHALL REPORT TO THE ASSOCIATION.

Section 2. The Committee on Nomination shall nominate to the convention the names of the candidates for President, three Vice-Presidents, EXECUTIVE Secretary, Treasurer, and ONE OR MORE Trus-

tees at the first appointment shall be so adjusted that one member shall go out of office annually. This Committee shall undertake such study or activity as may advance progress of out-patient service and shall report to the Association.)

(Section 6. The Committee on the Development of the Association shall present annually a report on the further development of the Association's work.)

(Section 7. The Committee on Publication shall receive the minutes of the Secretary concerning all transactions of the Association or its sections, and all papers read at any session thereof; and authorize or forbid the publication of all or any part of such minutes or papers as a part of the proceedings of the Association in the report of the Association or in any paper or magazine approved by the Committee.)

Section (8) 6. The Legislative Committee shall so far as possible inform itself concerning all legislative procedure affecting the Association or the interests which it represents. (and communicate the same to the Association by an annual report or by such other means as the Trustees may approve.)

SUBJECT TO THE APPROVAL OF THE ASSOCIATION OR BOARD OF TRUSTEES, IT SHALL ACTIVELY SUPPORT ALL DESIRABLE LEGISLATION AND ACTIVELY OPPOSE ALL UNWISE LEGISLATION.

ARTICLE V

DUES

SECTION 1. CONSTITUENT INSTITUTIONAL MEMBERS SHALL PAY ANNUAL DUES AS FOLLOWS: HOSPITALS OF LESS THAN 100 BEDS SHALL PAY ANNUALLY \$10, HOSPITALS OF 100-250 BEDS SHALL PAY ANNUALLY \$25, HOSPITALS OF MORE THAN 250 BEDS SHALL PAY ANNUALLY \$50. ALL

OTHER INSTITUTIONAL MEMBERS SHALL PAY ANNUALLY THE SUM OF \$10. STATES, COUNTIES AND MUNICIPALITIES SHALL PAY IN ACCORDANCE WITH THE ABOVE SCHEDULE FOR EACH INSTITUTION ACCEPTED TO MEMBERSHIP.

Section (1) 2. Dues of active PERSONAL members shall be \$5 and of associate PERSONAL members \$2 for each calendar year. Life PERSONAL members are exempt from the payment of annual dues. Dues shall be payable on or before the first day of March of each year at the office of the EXECUTIVE Secretary.

Section (2) 3. If said dues are not paid on or before the closing of the annual convention for the current year, the EXECUTIVE Secretary shall notify the members in arrears, enclosing a copy of this section; and if said dues are not paid on or before the succeeding first day of January, the delinquent member shall be suspended and thereafter shall not be entitled to receive notices, or copies of the transactions, or to participate in the meetings until all arrears are paid in full.

Section (3) 4. At any time within three years after the date when dues are first required to be paid a member who has been suspended shall be reinstated upon the payment of the amount due at the time of suspension. Otherwise membership in the Association shall be terminated.



St. Luke's Hospital, New York, one of the hospitals which delegates will be able to inspect on their way to or from the meeting.

ARTICLE VI PUBLICATION OF PROCEEDINGS

Section 1. The EXECUTIVE Secretary shall furnish the minutes and proceedings of the regular meetings for publication as soon thereafter as practicable.

Section 2. The EXECUTIVE Secretary shall furnish to each member, except as provided in Article V, Section 2, a copy of this publication.

Section 3. (*The Secretary shall, upon certification of the Treasurer*) THE TREASURER SHALL UPON THE CERTIFICATION OF THE EXECUTIVE SECRETARY pay all bills for printing and publication of the proceedings of the regular conventions.

Section 4. No paper shall be published in the minutes or in any magazine or paper as a part of the transactions of this Association except with the approval of the (*Publication Committee*) TRUSTEES. All papers read at any session of the Association or its section shall become the property of the Association, and when so requested (*By the Committee on Publication*) The Board of Trustees (*shall*) MAY cause the same to be copyrighted in the name of the Trustees; but, unless prohibited by (*The Committee on Publication*) THE TRUSTEES the authors of all papers read at sessions of the Association or its sections may cause the same to be published, and, if approved by the (*Committee on Publication*) TRUSTEES they may be published as a part of the transactions of the Association. No paper or magazine shall be entitled to the exclusive publication of any paper read before the Association or its sections except by vote of the Trustees.

ARTICLE VII SECTIONS

Whenever a section is established by the ASSOCIATION OR Trustees as provided in the constitution, the President shall appoint a chairman and secretary thereof; and thereupon any DELEGATE OR member of the Association may become a member of such section by enrollment therein. When ten (10) or more DELEGATES OR members have so enrolled, the chairman shall call a meeting of such DELEGATES OR members, and they may thereupon make proper rules and by-laws for the guidance of such section, subject to the approval of the Trustees; and such rules may provide for the method of holding meetings, election of officers, and other matters necessary or important for the proper conduct of the section. The chairman and secretary appointed by the President shall act until their successors are chosen by the members of the section in accordance with the by-laws established by such section.

ARTICLE VIII GUESTS

DELEGATES AND members of the Association may have the privilege of inviting guests to the meetings, under such rules and regulations as the Trustees may from time to time provide. Guests thus introduced shall be permitted to participate in discussions.

ARTICLE IX DISCIPLINE

Section 1. All charges of violation and infraction of rules or unbecoming conduct shall be referred to a special investigating committee of five appointed by the President.

Section 2. Due notice of the charges shall be given to the alleged offender, in writing, by the EXECUTIVE Secretary of the Association.

Section 3. The Association shall have the right and authority to reprimand, suspend and expel any DELEGATE OR member guilty of violation of any of the provisions of the constitution or by-laws of the Association, after a full and fair investigation shall have been made.

Section 4. A four-fifths vote shall be necessary to sustain the action of such committee.

ARTICLE X AMENDMENTS

These by-laws may be amended as provided by Article IX of the constitution.

Special Opportunity for Delegates to Visit Hospitals in New York City, Philadelphia and Baltimore

Arrangements are being completed which will give members of the association and delegates to the convention an opportunity to go in groups to visit and inspect leading



General view of the Rockefeller Institute Base Hospital, East Sixty-fourth street and Avenue A, New York.

hospitals in New York, Philadelphia, and Baltimore. A committee has been appointed in each city to look after delegates who may wish to stop over and visit hospitals in these cities on the way to or from the convention. The chairman of the New York Committee is Dr. Thomas Howell, New York Hospital, 8 West Sixteenth street, New York City; the chairman of the Philadelphia com-

mittee, Mr. Daniel D. Test, superintendent Pennsylvania Hospital, Eighth and Spruce streets, Philadelphia; the chairman of the Baltimore committee, Dr. R. B. Seem, assistant superintendent Johns Hopkins Hospital. Individual delegates desiring to visit these cities on the way to the convention may write to the above-named chairman for advice and information. Delegates wishing to make



Bellevue Hospital, New York. (Photograph by courtesy of the New York Edison Company, to whom acknowledgment is made.)



Mount Sinai Hospital, New York.

any of the trips after the convention should notify the executive secretary at Atlantic City, who, with the respective chairmen, will endeavor to complete necessary arrangements.

Hospitals and Other Institutions in New Jersey Which May be Visited by Delegates to the Convention

ATLANTIC COUNTY HOSPITAL FOR TUBERCULOUS DISEASES

Dr. I. E. Leonard, chairman of the local committee on arrangements, is arranging an automobile trip for delegates to the Atlantic County Hospital for Tuberculous Diseases, located at Northfield, N. J., seven miles from the city, over the boulevard. This is a new county institution, built under the terms of the 1912 act of the New Jersey legislature empowering county boards to establish county

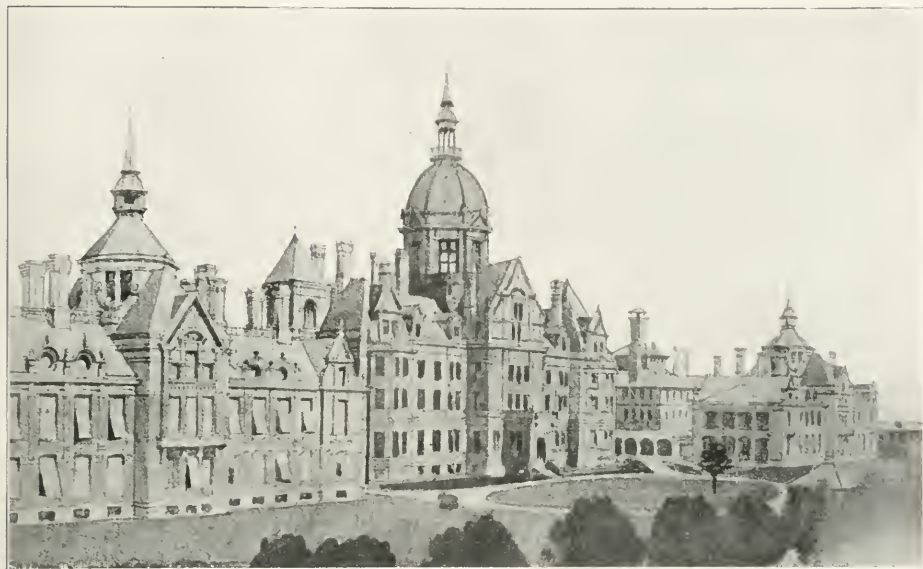
hospitals for the care and treatment of persons suffering from tuberculosis. It is an attractive, modern institution. In each of the two years of its operation, according to official reports, it has cared for over 100 patients. The superintendent is Dr. Clyde M. Fish.

THE TRAINING SCHOOL AT VINELAND, N. J.

A cordial invitation has been issued to the members of the American Hospital Association and delegates attending its twentieth annual convention to visit two great institutions for the feeble-minded at Vineland—the Training School for the Feeble-Minded and the New Jersey State Institution for the Feeble-minded. Delegates wishing to visit these institutions on the way to the convention should communicate now with the executive secretary or



Panoramic view of Sea View Hospital, New York.



Johns Hopkins Hospital, Baltimore

at the convention for a later visit. A visit to either one of these institutions is an education in itself. The Training School is a large institution, covering many acres with a number of buildings. There are 120 girls and 265 boys at the Training School and 100 at Menanico Colony. The work being done under the direction of Dr. E. R. Johnstone

is modern, progressive and scientific. Results are being accomplished.

NEW JERSEY STATE INSTITUTION FOR THE FEEBLE-MINDED

The State of New Jersey has adopted a progressive policy for the institutional care of the feeble-minded. The New Jersey State Institution for the Feeble-Minded at



German Hospital, Philadelphia



Jefferson Hospital, Philadelphia.

Vineland, which now has a capacity for 750 patients, is the present expression of a definite plan of institutional development which will eventually include accommodations for 1,500 feeble-minded in a central plant; colonies for 1,000 additional patients; a research department; and special classes in the public schools for feeble-minded children not a social menace. The rapidity with which this plan will develop depends upon the state legislature. A visit to the institution and a talk with the superintendent will convince one that the framers of the New Jersey plan recognize the problem of feeble-mindedness. Dr. Madeleine A. Hallowell, medical director and superintendent, extends a cordial invitation to delegates.

Atlantic City—the Playground of the World*

Atlantic City, the playground for the whole world and the greatest seaside health resort, has grown from a few summer cottagers in 1854 to a city of 50,000 permanent citizens. Dr. Jonathan Pitney, of Absecon, N. J., recognized in the large island of sand five and one-half miles to the southeast of the New Jersey coast the unprecedented advantages for giving his patients the open air treatment for disease. While not the first to visit Absecon Island, on which Atlantic City is located, he was practically the real promoter of the present magnificent city.

With a permanent population of 50,000, the city increases to 300,000 by the height of the season in August; and, what is more gratifying, this large army is properly housed, dined and entertained. The capacity of the hotels without crowding ranges from 1,100 down to the small boarding house and cottage. It is a "city of hotels." With 100 large hotels, over 900 smaller hotels and boarding houses and about 9,000 cottages and other buildings, one can read-

ily realize the ease with which one's comfort can be met. Atlantic City's one aim is the entertainment and comfort of her guests; she can not be classed as a manufacturing or commercial center. Its terminus is in the ocean and its only commodities in trade are fresh air, sunshine, good accommodations, wholesome food, pure water and the pleasure and health of its guests.

THE BOARDWALK

Atlantic City's Boardwalk is unique; nowhere in the world can one find its duplication—a steel and reinforced concrete substructure with a Georgia pine deck, elevated from 5 to 15 feet above the beach, 8 miles long and 20 to 60 feet in width. On one side is an unobstructed view of the ocean and beach, while the other is lined by hotels, places of amusement and bazaars. It is on this structure that one will find a regular kaleidoscopic moving mass of humanity representing every state in the Union and every civilized nation of the earth; "Babel let loose" as one expressed it. In fact, "Meet me on the Boardwalk at Atlantic City" has become one of the world's by-words.

Six piers, each over 1,000 feet in length, extend from the Boardwalk into the sea, and on them one can find amusement, recreation, fishing, or a peaceful rest at all times of the year. Open in summer and heated in winter, the music halls provide the very best high-class music.

RECREATION

Surf-bathing is the most popular form of amusement and recreation in summer. The beach is safe, and slopes

*From data furnished the Association by the Publicity Bureau, Atlantic City, N. J. Geo. S. Lenhart, Sec'y-Director.



One of the buildings at Burlington County Colony for the Feeble Minded.



Feeble-minded boys of Menantico Colony hoeing sweet-potatoes. Farm work appeals particularly to such boys, and they are capable of being very useful at it.



Children's Seashore House, Atlantic City.

gently to deep water 50 to 100 yards from shore, is covered with fine sand, and is free from rocks and other injurious features. Sea ropes are unknown. Many bathers enjoy the surf during the winter months. Indoor swimming pools are also at one's command.

Yachting and fishing are two forms of entertainment and recreation always available. Here one can have a sail on the bays and thoroughfares on smooth water or on the ocean, where the roll and toss of the waves are fully experienced. Atlantic City is not a port of entry, but the inlet channel is now on the United States Gov-

ernment and State of New Jersey appropriation bills and will be deepened to accommodate the largest pleasure craft. The whole city and Boardwalk are so carefully policed at all time of the day and night that ladies can come and go without escort or fear of molestation.

The Country Club, located at Northfield, seven miles away, affords every opportunity for golf and other outdoor sports at all seasons and can be reached by trolley at any hour.

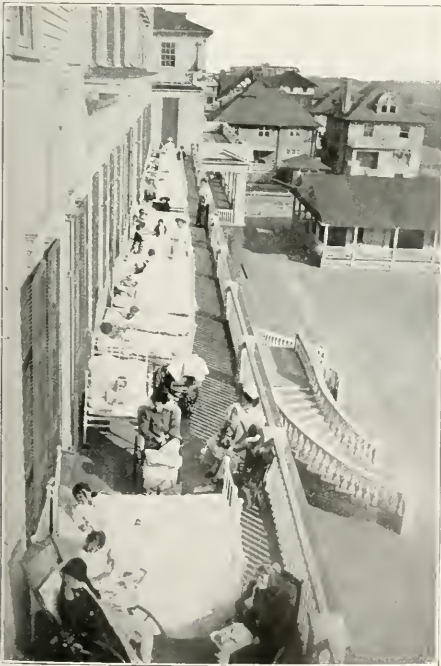
THE ROLLING CHAIR HABIT

The rolling-chair habit has grown to such phenomenal proportions that not only do invalids use these easy vehicles, but the average visitor can make use of them as he would of the taxicabs and carriages. This affords every opportunity to enjoy the climatic influences and the beauties of the sea.

THE CITY ITSELF

Just a word or two about the city in general. It is ruled by a commission of five members. There are twelve school buildings graded to the highest standard, preparing pupils for any college; thirty odd churches representing all denominations; a most efficient paid fire department of fourteen separate companies; a thoroughly trained corps of municipal life guards and medical men on the beach during surf-bathing seasons; nine banking institutions and trust companies of the highest rank—in fact, everything that goes to make an up-to-date city. The city streets are well paved and are kept in a perfectly clean condition by the city's "white wing corps." There is no city in the world better able to care for conventions of all sizes and to give almost unlimited accommodation of the very best kind without crowding and over-charging. An influx of 10,000 to 20,000 people is no longer a novelty, and they are so well cared for and with such little effort that their presence is scarcely noticed except on the Boardwalk.

Hotels range from the palatial beach front structures of steel and concrete to the more unobtrusive little boarding houses on the side streets. Money has not been spared to provide for the comforts of their guests. One can find every home comfort at command, winter and summer. The rates charged by these hotels are within the reach of all, and are proportionately low when compared with other cities. Many of them supply hot and cold, fresh and sea-water baths with each suite of rooms. Special diet kitchens for the preparation of food for invalids and the sick are noticeable features of the best hotels.



Sun bath porches at Children's Seashore House. (Note the mothers' cottages below the porch.)

EXCELLENT RAILROAD SERVICE

Few cities have better railroad service than Atlantic City. The Pennsylvania, the Reading, and Central Railroad of New Jersey and electric lines have Atlantic City branches. The city is reached in one hour from Philadelphia by some of the fastest trains and in three hours from New York.

Hospitals of Atlantic City

THE CHILDREN'S SEASHORE HOUSE FOR INVALID CHILDREN

Atlantic City has in the Children's Seashore House for Invalid Children the largest children's institution devoted to thalasso-therapy in America. It has accommodations for four hundred and annually cares for over thirty-six hundred persons. It is also the oldest institution of the kind in the country.

It was organized in 1872 and began its work then in a little cottage containing thirteen beds. The following year it was opened in a building erected right on the beach for its special purposes, with accommodations for forty children.

As its work grew during the succeeding twenty-eight years, the capacity of this building was increased until there was room in it and its dependencies for two hundred and twenty-five patients.

In 1902 its old quarters were abandoned, and its present commodious group of buildings was erected with accommodations in all its departments for over four hundred.

The institution was intended for the sick and delicate children of Philadelphia, and among its first inmates were children from the hospitals of the city. During the first thirty-eight years of its existence it was open in summer only, but since 1910 some portion of the institution has been open throughout the year.

At first only children under twelve years of age were admitted, but gradually its scope has been widened until now it receives children of all ages, from the youngest infant to the girl of twenty, and in its summer camp off in the sand dunes, boys of sixteen.

The work of the institution may be classified under four heads: First, the baby-saving work; second, its fortifying work for delicate children not yet ill; third, its work for convalescents; fourth, its work for children with bone and gland diseases.

MUNICIPAL HOSPITAL FOR THE TREATMENT AND DETENTION OF CONTAGIOUS DISEASES

This institution has accommodations for 64 patients, and its capacity can easily be increased to 100. It is a handsome, artistic, fireproof building. The hospital has four wards, one for diphtheria, one for measles, one for smallpox and the fourth for scarlet fever. The administration building is occupied by the offices, the drug room, the kitchen and dining rooms and bedrooms for members of the staff. In addition to the public wards there are handsome private rooms, either single or en suite, which may be engaged by patients who may be willing to pay in proportion to the accommodations placed at their disposal.

ATLANTIC CITY HOSPITAL

Atlantic City Hospital is an incorporated charitable institution. It is a general medical and surgical hospital with an average daily attendance of hospital patients in 1917 of 76. It admits pay, part-pay and free patients, and conducts a training school for nurses. Its general superintendent, Miss F. Virginia Ludekens, is a member of the American Hospital Association and of the local committee. She will welcome delegates who wish to visit the hospital.

REMARKABLE WORK OF AMERICAN RED CROSS

Extent of Hospital Facilities—Testimony of Henry P. Davison to Red Cross Volunteer Work

The hospital facilities for our army are necessarily enormous, and innumerable emergencies inevitably arise, according to a statement by Henry P. Davison in the *Red Cross Bulletin*. He says:

"We have warehouses throughout France and Italy with an extensive automobile transportation system, making it possible to place supplies on short notice. Our whole service was subjected to extraordinary demands during the recent German drive.

"In France, we maintain thirty-seven warehouses for the reception and distribution of goods. The daily receipt of merchandise is sometimes as much as one hundred tons. In one warehouse there are seven thousand tons of provisions. We have upwards of seven million dollars' worth of goods in our warehouses. When these goods are needed their value is above price.

"Up to the time I left, our Red Cross had either distributed, or held available for immediate distribution, more than twenty-two million surgical dressings and bandages.

"We are operating a hospital supply system for 4,361 hospitals in 1509 cities in France. Their needs range from safety pins to complete radiographic installations, and have actually included oxen to plough fields and cows to give milk for use in tuberculosis hospitals.

"Since July 1, 1917, we have supplied hospitals in France with 3,375,000 separate articles. In Italy we are sending supplies to 465 hospitals. We are operating 99 ambulances along the Italian front, driven by 129 American boys.

"We are serving both the French and the American soldiers right up behind the lines with rolling canteens, and also providing rest stations and canteens at railroad stations.

"In fourteen milling canteens at the French front 3,240,000 hot drinks have been served to French soldiers. At eleven canteens on the French lines of communication we have supplied 3,913,000 meals. In fourteen canteens in the Paris district in France we have supplied 4,251,277 soldiers with food and drink. Our activities among the soldiers at the front in Italy are on a corresponding scale.

"We have established a factory to make artificial limbs according to the best American practice and have distributed more than a thousand artificial legs and arms to mutilated French soldiers. Five splint factories are operating under our supervision, making 15,000 splints and accessories a month for the United States army hospitals and supply depots.

"Our Home Communication Service has just been fully organized. It searches for American soldiers in all the hospitals, writes letters for them, and to any man, sick or well, offers home help in whatever form it may be needed.

"This service also searches for missing men, and locates prisoners. It marks the graves of the soldiers who die. This service acts as the line of communication between the American boys in France and the families and friends at home. It helps them to get information about each other.

"The American Red Cross is itself operating thirteen hospitals in France, two in Italy, and five in England. We are also operating a large number of dispensaries in France, England and among the Belgians.

"Our activities extend from Scotland to Sicily, and a very large part of the work is being done by American volunteers. We also have important work still going on among the refugees in Macedonia."

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XI

October, 1918

No. 4

THE EDWARD L. TRUDEAU INSTITUTION IN FRANCE

A Worthy Memorial to a Great American and Beloved Physician of French Descent—A Center of Education as Well as of Healing

By WM. CHARLES WHITE, M.D., RECENTLY CHIEF, BUREAU FOR THE CARE AND PREVENTION OF TUBERCULOSIS, AMERICAN RED CROSS IN FRANCE

"WITH our friends the Americans, he was a figure almost legendary, comparable with Laennec or Pasteur. He merited a book. Edward L. Trudeau is within his right in history. His name will pass to posterity as that of a great crusader. The world will guard the memory of this generous founder of popular sanatoriums in America, of this philosopher-doctor, this courageous philanthropist, who had the good fortune to concentrate his intelligence and assistance on the defense of those suffering from tuberculosis." Thus in 1916 wrote Professor Maurice Letulle of America's beloved physician, who was of French parentage but born in America, and who was one of her most priceless possessions.

Our part in the struggle when the American Red Cross came to France in the summer of

1917 was to assist in the fight against tuberculosis—a fight serious at any time but thrust into prominence in all countries by a war which produced food-shortage, overwork, congested housing, severe prolonged strain and new, unnatural conditions for large groups of the population.

In France, the great battle-ground, as she has been for ages in the world struggle for freedom, conditions naturally were most severe. Besides

her own normal population, she was traversed by all the allied armies passing to and from the war zone—British, Americans, Italians, Belgians, Portuguese, Serbians, and Africans, as well as her own wonderful troops—and in those departments outside the war zone she was the haven of all who were displaced by the war, refugees before the German advance, repatriates from behind the central lines, Belgians, Serbians, and many others in small groups. In all of these there would have been enough tuberculosis at any time to occupy a great force of people; it was multiplied by the conditions of war.

France was awake to the demand and coping with it in the same spirit with which she has met all that has been forced upon her, but there was also great need for our help and she accepted it

with the generosity which has spelled the heart and minds of her leaders. We were not needed to show her the way. Was she not the home of Laennec, who taught us how to detect disease in lungs, of Villemin, whose name stands preeminent in all the foundation knowledge of the tubercle bacillus, and of Calmette, the father of the dispensary, the greatest implement of all in the modern warfare against tuberculosis? Was she



Fig. 1. One of the châteaux, situated in a beautiful woodland region, which have been taken over by the Edward L. Trudeau Institution in France for use as a tuberculosis sanatorium.

not a country with model sanatoriums at Bligny, Berck, Hauteville, and many other places, and with dispensaries and nursing schools springing up everywhere? Had she not Letulle, Besançon, Guinard, Kuss, Rist, Bernard, and Courment leading the way? Any who thought of teaching



Fig. 2. A vista down the beautiful woodland park surrounding the buildings of the institution.

soon found that we were needed not for that, but rather to help in the great burdens arising from the emergency which crowded her own population into one quarter and all the allied armies into the other three quarters of her territory.

The most urgent need was help for her tuberculous civil population, refugees and repatriates, dislocated homeless, and transient and broken families.

Early in the autumn of 1917 the first opportunity for independent work came. Prior to that time we had given assistance to French hospitals and organizations already organized for the task. But in October members of the English Mission of the Society of Friends asked us if we would undertake to reconstruct and operate a property near Paris which had been offered to them by the Department of the Interior for the care of tuberculous refugees. This property lies in two sections about a mile apart, covering about a hundred acres, with three large buildings and a number of typical French outbuildings. It had been purchased before the war by the Department of the Seine to fulfill a plan for a garden city of which Mr. Henri Lucien was the originator. It is only twelve miles from Paris, easily accessible by train or automobile.

Conferences were at once begun with the Department of the Seine, the Department of the Interior and the English Friends; and the whole property was turned over, rent-free, to the American Red Cross for the duration of the war and six months thereafter.

By the middle of November conferences and plans were completed and a group of American

Friends began the work of cleaning, papering, plumbing and equipping. On Christmas day, 1917, six weeks after the work was begun, the first three tuberculous refugees were admitted in the midst of the confusion of work still under way.

Through the generosity of private owners, it became possible in the following months to secure two additional châteaux in the immediate neighborhood on the same terms as those granted us by the Department of the Seine. After obtaining the permission of the owners for all changes made



Fig. 3. A group of convalescents enjoying the open air.

in the buildings the American Red Cross agreed to pay for them and for the current taxes and insurance.

We decided to use these five large buildings and the adjoining land for the tuberculous refugees



Fig. 4. One of the wonderful views which abound in this region.

and repatriates, chiefly women and children and their families.

The largest of the buildings, known as the Château Hachette, was turned into a hospital of eighty beds for women with active tuberculosis. The next in size, called the Sertillange Home, was converted into a hospital for eighty children. The third, just across the road, was

made a receiving ward of forty beds into which all children were taken for two weeks' isolation before entering the hospital proper to protect the other groups against infectious diseases. Following this, the orangerie of the Hachette house was converted into a ward for twenty-five tuberculous women, and finally this whole group was augmented by wooden barracks to take care of twenty-five children of tuberculous families; in all, 475 beds. To these were added other barracks for dining rooms, kitchen, school and play rooms.

In all of France one could not have found a more pleasing or beautiful spot into which to receive the unfortunate sick driven from their homes by an invading army. All the buildings are grouped around a woodland park of many acres with wonderful vistas and walks in which the children are allowed to play, and on the ter-

sixty acres of land, and opened our "school for housing." In planning Malabry we aimed to meet an emergency and at the same time to create an organization which would be of subsequent



Fig. 5. A row of the cottages erected on the Malabry estate for tuberculous families.

aces and slopes are ideal places for those who need rest, fresh air, and sunshine.

Not all has been quiet, however. For many nights the patients were reminded of the frightful region from which they had fled, as the many Gothas dropped their bombs on Paris or the long-range cannon threw its shells in the direction in which the new hospital lay. At such times our American doctors and nurses were roused to carry the sick and fearful into the cellars of the old château and to quiet the fears of those in whom the bursting bombs aroused such horrible memories. Again, in spite of all its beauty, sadness crept over the scene only too often. When Major Murphy first came to see it and the patients asked the privilege of singing the Marseillaise, it took some blinking to hide the tears.

This group of 450 beds did not begin to satisfy the demands that came to us. There was still, as everywhere, the homeless in refuge that would not separate from its sick. All were full of the hope of returning to their former homes when the devastation had ceased. To provide for these we took the Malabry estate, two châteaux and



Fig. 6. A group of members of the Society of France in their working uniform. They do all the work about the estate.

value in the reconstruction era. Each houseless refugee family with a consumptive member is given a small wooden house fitted out anew; the whole family, well or sick, will be under constant medical supervision, and when the war ends the family will be sent back, house equipment and all, to the village of its choice, with the new and priceless knowledge of how to live with a tuberculous member in the household, to care for him and to protect the others. They will be taught new trades, if necessary; the children will be taught by the teachers of the French department of education in open air schools. We are to begin with a colony for two hundred houses, approximately one thousand persons, with schools, workshops, stores and a chapel. Each household will become a center of education in the village to which it returns. We have learned lessons from the housing of vast armies in the field under healthy conditions, and it is hoped that through this demonstration the possibilities of simple installations will be established for our whole tuberculosis campaign.

To this entire group of activities, caring for fifteen hundred refugees in which tuberculosis is a common factor, we gave the name of Edward L. Trudeau, Frenchman by origin, American by birth, who gave forty years of his life to the fight against the disease. His name honors both the American and French nations, as well as this new institution, and helps to draw the two republics together in another common battle. We only would that we could honor him more.

HOSPITALS CAN SAVE FUEL IN MANY WAYS

Two Classes of Hospital Heating Plants—Rules to Be Patriotically and Carefully Observed in Heating Large and Small Institutions—Maximum Efficiency Possible with Lessened Tonnage

PREPARED FOR THE MODERN HOSPITAL BY THE UNITED STATES FUEL ADMINISTRATION, WASHINGTON, D. C.

DEATH and destruction there must be on the battlefield in spite of the supreme efforts of doctors and nurses, but on this side of the Atlantic death and illness are more readily controlled. Now as never before it is our duty to make our death rate low.

Those in charge of the heating plants of hospitals are hearing the call of the nation's fuel army and are bending every effort to save coal. For them a double duty to humanity awaits. They must guard the lives of those entrusted to their care, and they must save fuel to preserve those who are fighting for their country's life.

Hospital heating plants divide themselves into two classes. The small hospitals are heated by regular house-heating plants, and the others by large power plants. The Bureau of Conservation has ruled that all steam plants operating on 15 pounds' gauge pressure, or under, when not over 150 total boiler rated horse power, will come under house-heating plant rules. All others will be considered power plants.

A few rules should be patriotically and carefully observed by all who have the heating of any building, large or small, as their special task.

1. Storm windows and storm doors, weather-strips, and other protective devices should be provided.
2. It is wasteful to allow the temperature of a room to go *too low* at night because a great deal of fuel is required to raise it in the morning.
3. Use your thermometer and regulate the heat. Much coal can be wasted by guessing at temperatures.
4. Know your heating plant and regulate it thoughtfully.
5. Keep your heating plant absolutely clean.

IF YOUR HOSPITAL IS SMALL

If the hospital in your charge is small, the rules

applicable to house-heating plants are the ones for you to know and follow. Perhaps you know many of them already, but the few you have missed may stand between you and the saving of a ton of coal.

There are a few general rules which apply to the operation of hot-air, steam, or hot-water plants:

1. Be sure there is a check-draft damper in the smoke-pipe besides the turn-damper. This check-draft damper is important in controlling the rate at which the fire burns. Open it to check the fire. Close it to make the fire burn more rapidly.

2. The turn damper should fit the smoke-pipe closely and must never be entirely closed.

3. If you are using soft or bituminous coal, make use of the lift or slide damper in the coal door only to let oxygen in to consume gases, after fresh coal has been added.

4. Just enough draft and that from below, checking the

draft by letting more air into the smoke-pipe, is a good general rule. This furnishes oxygen from below to consume the coal gases, and gives time for them to be consumed before being drawn up the chimney.

5. All heat pipes in the cellar should be thoroughly wrapped with asbestos or similar covering.

6. Grates should be cared for properly. A short, quick stroke of the shaker handle will sift the ashes through the grates. Leave grates in flat position when through shaking.

7. Avoid poking and slicing the fire-bed. It causes draft holes and clinkers.

8. Never shake a fire that is low unless you have put on a little fresh coal and given it time to ignite.

If you operate a hot-air furnace there are a few specific facts about hot-air heating which you should keep ever in mind.

1. Provide cold-air drops from upper floors so as to insure a return circulation from all rooms to the air intake of the furnace.

2. Regulate the window of the cold-air box so as to avoid too great a current of outside air, especially on very cold days.

TO SAVE OUR SOLDIERS.

Our war is a war of steel. The army that can amass vast quantities of shells and guns is the army that will make the Great Drive which will win the war.

Unless we amass these products of war in vaster quantities than Germany can amass them, we shall hurl our soldiers to destruction.

But steel waits upon coal. Not a ton of raw steel can be made and transported without five tons of coal.

The nation hears the bugle note that calls the coal army into action. Miners have answered to the reveille. Railroads have responded to its summons. The coal conservationists in homes and industries must likewise hear it.

Will our hospitals, always agents of mercy, add to their great service by saving coal to produce more steel and thus reduce the list of casualties?

3. Always keep the water container in the air-jacket filled with clean water. Moist air heats much more readily than dry air.

4. It is advisable to keep a jar of water near one of the first-floor registers that sends out the moist heat.

5. Hot-air pipes should have a good pitch upward from the furnace, and should be of sufficient diameter. They should also be covered with asbestos.

6. Be sure the fire-box is gas-tight. All cracks must be thoroughly cemented or a new section put in before winter.

Steam heaters require a separate set of specific rules in addition to the general ones in order that they may be rightly operated.

1. The water in the boiler should be completely changed at least as often as every spring and every autumn. Draw a bucketful of dirty water from the bottom at least twice a week and replenish it with fresh water.

2. Look at the glass water-gauge whenever you attend to the fire. Turn the exhaust-cocks above and below the gauge occasionally to make sure that it is not clogged or the openings to it from the boiler closed up.

3. The level of the top of the water must always show at some point along the gauge. Its height will vary with the temperature of the water. If it rises above the top of the glass there is too much water in the boiler and some must be drawn off; if it sinks below the bottom more water must be let in.

4. Be sure that the exhaust valve of each radiator works. Sometimes these valves need cleaning with a pin or soaking in kerosene. They *must* be kept clean.

For the operation of hot-water heating plants still other rules must be observed.

1. All the water should be emptied from the plant and clean water put in at least as often as every spring and autumn.

2. When the first fire of the season is built, as the water gets heated, take the radiator key and open up the exhaust valve of each radiator in turn until all the air remaining in each radiator is allowed to escape. Make sure there is no air to interfere with the free circulation of the water.

3. Always be sure the water shows in the glass gauge of the exhaust tank, which is usually located in the top story of the house above the level of all radiators.

FOR HOSPITALS WITH LARGE HEATING PLANTS

If the hospital over which you have supervision has a heating plant which according to rules comes under power plant regulations, this set of recommendations should be posted where your firemen will see them frequently:

1. Keep a daily record of coal consumption, recording such weights in the boiler room. A low rate of combustion per square foot of grate surface means waste. The coal burned per hour, divided by the grate surface in active use, will give the pounds of coal per square foot of grate surface per hour. For hand fire furnaces with soft coal this figure should not be less than 15 to 20.

2. Keep daily records of feed water consumption. This, with the coal record, permits calculation of water evaporated per pound of coal. Use exhaust steam for heating feed water. Steady or regulated feed of water is a source of economy.

3. Determine the air pressure to the furnace with draught gauges, connected to the furnace or breeching.

It eliminates guesswork and insures a proper supply for combustion. Regulate the draft on the boilers with main flue damper, after setting individual dampers on each.

4. Tubes should be frequently and thoroughly cleaned and feed water properly treated to prevent scale formation on the inside of the boiler or tubes.

5. Grates should be in good repair, and setting, breechings, and access doors should be free from air leakage. Surfaces wasting heat should be covered with insulation of ample thickness.

6. Steam piping, drums, and feed-water heaters should be properly covered with insulating material.

7. Some special person should be designated to look after fuel conservation in the entire building and heating plant. In this way many economies may be accomplished that would otherwise be overlooked.

DO NOT OVERHEAT ANY ROOM

The doctors and nurses will know just what temperature their various patients need. Be sure no room is overheated.

According to Dr. Ellsworth Huntington of Yale University, a varied temperature, averaging from 60 to 64 F., is best under ordinary circumstances for the human race. Every living thing has a temperature at which it can do its best and above or below this there will be trouble. Moist air is more healthful than dry, provided it is not too warm, so it is necessary for the heating plant operator to see that the air in each room has enough humidity. It is advisable to keep a jar of water in heated rooms so that the air may absorb moisture from the water instead of the body.

Use all thought to save every pound, every ounce of fuel possible by operating the hospital heating plant with maximum efficiency. Every agency in the United States is enlisted in the army to save fuel, the foundation of all war activities. Hospitals have their share in the fight to provide more coal for war needs.

The Quarantine Stations at Didam, Sittard and Venloo

Great wars are always accompanied by epidemics of infectious diseases. During 1916 and 1917 several epidemics of smallpox and typhus fever broke out in various parts of Germany. As numerous deserters and escaped prisoners of war entered Holland from the eastern frontier, the Dutch government was compelled to erect special quarantine stations to protect the health of its people. For economical reasons it was decided to erect three large stations instead of numerous small ones. Each station consists of a disinfection building, a hospital with a number of divisions for the various infectious diseases, including sexual and skin affections, a building for the military force, a house for examining deserters, offices, storerooms, etc. As the incubation period of the various infectious diseases differs very much the average duration of observation, to which all quarantined persons are subjected, is twelve days. R. N. Eykel describes these stations in a number of the *Ziekenhuis*.

Cheerfulness is the daughter of employment, and I have known a man to come home in high spirits from a funeral merely because he had the management of it.—Dr. Horne.

THE HOSPITAL OF EXTENDED GRACE TO WOMEN AND CHILDREN

Strange Customs Reflected in Hospital Life and Construction—Warm Floor Method of Heating Successful and Economical—Success of Korean Women Physicians and Trained Nurses

BY MRS. ROSETTA SHERWOOD HALL, M.D., HARRIS HOSPITAL, EAST GATE, SEOUL, KOREA.

WHAT would THE MODERN HOSPITAL think of a dispensary waiting room without seats, and of hospital wards without beds? Such was our style always in the early days in Korea, and a number of our more "modern" hospitals continue this plan for our Korean patients. And why should they not? We western physicians came to

—usually three—the kitchen, a room for the female members, and one for the male members of the family. If there be but two rooms in the house, the one is shared in common, as sleeping-room, dining-room, and living-room; but if there be the "inside" room for the women, and "outside" room for the men, then the tables of food from the kitchen are each sent to their respective departments, and there is no common living room. Since Koreans sit, eat, and sleep on the floor, with



Fig. 1. The Hospital of Extended Grace to Women and Children, Pyeng Yang, Korea.

this land following the example of the Great Physician, whose precept is, "Heal the sick and say unto them, 'the kingdom of God has come nigh unto you.'" Now, Dr. Barton has said to us, "Don't go to the East to change customs that are indifferent." There are some customs in Korea that are not only indifferent, but are safer than the Western customs—for instance, the wearing of white clothes. This has been adopted by doctors, nurses, and street-cleaners the world over. Another time I may tell you more about this and other good features of Korean dress and customs.

The poorest Korean home contains two rooms



Fig. 2. Patients sleeping on the floor in the Female Ward of the Hospital of Extended Grace.



Fig. 3. Graduate nurse and two little patients with coxalgia in plaster-of-paris splints. The nurse first entered the hospital as a patient, having had the end of her nose cut off by a jealous husband.

but one living room, they are far more comfortable, strictly speaking, than a Western family because this room is so easily transformed into a sleeping room, dining room, or parlor as needed.

There is neither stove nor hot-air register to cause dust or dirt, and no room is taken up by steam or hot-water radiators, which also are apt to collect more or less dust and dirt. The entire floor is comfortably and most economically warmed by the same fire that cooks the food and heats the water for the family.

In the kitchen, with its floor of earth, the rice kettles are built in with tile and mortar at the side adjoining the living room, and the flues spread out under the entire living room; in short, the floor of the living room consists of these flues, or prostrate chimneys which converge into one outside chimney at the opposite end of the room. Since the blaze and sparks of fire are exhausted during their passage through this floor of stone and mortar, the outside chimney need not be high or fire-proof. Even in straw-thatched houses the chimney consists often of but a roll of matting or a hollow log projecting but slightly above the roof.



Fig. 4. Korean mother, twin babies and older daughter in the "Edith Margaret" children's ward.

The Koreans make the strongest and best paper in the world, and have a method of oiling it and making several plies into one. They cover their best floors with this paper, which, because of constant use, takes on a polish like marble. Because the Korean sits, eats, and sleeps on these warm floors, he follows the good custom of leaving his shoes outside the door, preventing the germs of the street from being carried into the room; and the polished floors are not defaced by the nail-prints of shoes, though dust-catching carpets or rugs are not used.

Lest I convey the mistaken idea that Korean homes are all patterns of cleanliness, I must explain that only the higher class or the well-to-do

use the oiled paper covering; the others practice customs that seem very far-fetched to us. They use only reed mats over the mud and stone floor, and conveniently turn them up to spit under; and they even allow their babies' urine to run through and dry in the warm floor beneath. But their customs are ideal in families knowing the principles



Fig. 5. Some of the October crop of Korean babies at the Harris Hospital, Seoul.

of cleanliness, strange though they may seem at first.

This method of heating by warm floors is peculiar to Korea, and though there is a hint of it in the Russian stove amid-walls, and in the Chinese kang, it seems that the Korean method excels by far in economy of fuel and space, and in so much as it keeps the germs of the street from being carried into the home.

The Japanese have no method of heating their rooms, save by a brazier which exhausts the oxygen and often adds carbon dioxide to the air. These people are progressive, being especially quick to adopt and adapt the best of every land; and in Korea, in their newer and better homes and hospital wards, they also use the Korean warm floors.

You may note that the Woman's Hospital of Extended Grace in Pyeng Yang appears in the

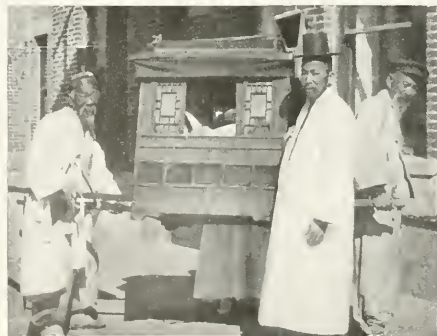


Fig. 6. Forty-year-old father taking home his wife and first children, twins born at the Harris Hospital, Seoul, in a Korean "palanquin," or carrying chair.

picture to be much like any other Western building, but it is quite different in its interior arrangement.

Koreans, having had the comfort and even luxury of these warm floors for generations, suffer great hardship, even though they are well and strong, when they have to sleep in cold beds. Children, old people, and the sick most of all, suffer very much. They often develop enteritis or pneumonia when they enter the foreign-bed hospital for some other trouble; and some have died when far worse cases have recovered in a hospital that has adopted the warm floors. A tuberculosis patient in a private room having these warm floors and keeping its windows wide open feels perfectly comfortable and happy the coldest weather. Delicate creeping babies improve so upon these floors! And after a tedious operation or a collapse, what could be better?

This arrangement is perfectly safe; the patient cannot get out of bed without the doctor's permission. There is no need of hot-water bottles; these prove a nuisance, as they burn, break, or spill; there have been cases where tiny American babies have been drowned by them.

The floor is quite sanitary. The smooth oiled-paper covering is wiped up with an antiseptic

solution as often as is necessary. By this means vermin, which so often infest beds in spite of the best care, can be kept away.

Then, a mission hospital is economical. There is practically no cost for beds and extra fuel. We also adopted the Korean plan of taking closet



Fig. 8. Deaf-mute pupil beating time in motion song for two blind pupils of the Department for Blind and Deaf, Pyeng Yang schools.



Fig. 7. Miss O (Prudence), the first blind pupil in Korea, who is now engaged in teaching massage to blind girls and Japanese to sighted students.

room from the upper part of the kitchen over the space reserved for the rice kettles. This, opening from the ward, makes a place, without taking up other room, to fold up the mattress and bedding used by convalescent or walking patients. By this means their part of the ward is easily transformed into a sitting room, or a dining room, when the individual Korean tables are brought in.

But to build a hospital in this way, the warm floor ward must be upon the ground floor; and, for economy, the dispensary, operating room, American doctor's rooms, and private rooms for American, European, and Japanese patients, upon the second floor. The tall brick chimney in such a building makes too great a draft for the fires in the Korean kitchen, and have to have dampers built in them. The Korean patients are practically all cared for on the lower floor, and therefore neither they nor their nurses have much climbing of stairways. Though the foreign doctor may have to strain her back and knees in order to count pulse, make physical diagnosis, attend to obstetrical cases, and do surgical dressings with the patients lying on the floor, the custom has its advantages, as pointed out above. Abnormal obstetrical cases we deliver on the

table, and any other difficult case can, of course, be lifted there at any time. Our Korean nurses, having been themselves brought up on the floor, find it no hardship to care for the patients this way; and now with the advent of Korean women doctors, the hardships foreign doctors have endured will largely pass away.

Oriental custom, having no seat, although the arrangement is of porcelain, level with the floor, having water flushings after our western fashion.

In-patients, dispensary patients, and out-calls, inclusive, number five thousand to seven thousand annually, to the average of one foreign doctor with native helpers largely trained by herself.

Now that we are beginning to secure graduate Korean nurses from our nurses' training school at Harris Hospital, East Gate, Seoul, and to engage Korean women physicians trained at the Medical College and Hospital of the Chosen Government General, we can, no doubt, do a far greater work.

During my twenty-eight years in Korea there has been a great change taking place slowly but surely concerning the kind of diseases and the character of patients frequenting our women's hospitals. Formerly only low-class women came, high-class women not being allowed to go upon the street except in closed palanquin, and then largely for surgical relief; later, however, they found that we could treat eye, ear, and skin troubles bet-

ter than the native doctor. It took a long time for them to believe our drugs were superior for internal medicine, or that the western physician could understand the inside anatomy of a Korean; however, from the first, we were called to the



Fig. 9. Our first deaf-mute pupil on her wedding day, showing the bride's dress and the "hams," or brass-bound boxes containing the wedding outfit.

Visitors always exclaim over the beautifully polished floors of our large waiting room and the rooms where the westerner seldom enters. Since our Korean patients only walk about in their stocking feet and seat themselves upon the floor, they keep it polished without any effort on our part.

One question that may arise within the inquiring mind is that of ventilation. I will say that this seems to be quite the reverse of ours. Fortunately, the windows can be kept open during the greater part of the year. In severe weather, when they must be closed, we note, when we enter a room heated by the Korean method only, that the upper air is cold, and one is not quite comfortable unless he is sitting or lying on the floor where the heated air is. Therefore in the hospital referred to we arranged for the fresh air to enter about on a level with the patients, and the foul air to escape at the ceiling. At any rate, ventilation is adequate.

The Korean habit of sitting comfortably in a squatting posture on the floor makes possible another sanitary custom—that of building privies without seats. And in our hospital we follow the



Fig. 10. Dr. Hall in her consultation room in the Hospital of Extended Grace.

homes of the high and the low for obstetrics.

Gynecological cases were so rare that it almost made us believe that Korean women did not suffer as much as others from so called "female complaints." But within the last decade the change has been marked. Women of the middle and higher classes now come freely to our women's hospitals and dispensaries; even wives of officials await their turn with the low-class women. And we find all the varieties of gynecological troubles of the homeland, and, owing to the results of the native forms of treatment, we see some variations that our professors never saw.

Last year, according to the record book, the diseases classified and in their numerical order were gynecological and obstetrical, medical, surgical, skin, eye, ear, nose, and throat. One-third of all new cases and one-half of the return cases were gynecological.

I was much pleased to read, in a recent number of THE MODERN HOSPITAL, of some hospitals in

Japan, and to see their pictures. I myself have visited the Red Cross Hospital in Tokyo, and can say that the very sane treatment described by Dr. Ishida for the insane patients of the Nagasaki Hospital certainly appeals to me.

As to equipment and general management of our hospitals for Korean women, perhaps I can not do better than to quote from a letter signed by Mr. T. Sekiya, director of Bureau of Education in Chosen. Mr. Sekiya has traveled in both the United States and Europe. He writes under date of March 2, 1918, as follows:

"Dear Doctor Hall: It was with great pleasure and admiration that I observed recently how your hospital is being carried on. It is well equipped, and is so clean and so comfortable! It gave me a most pleasant impression of your Korean nurses. They are as well trained as the foreign nurses, and they tend patients with warm kindness and affection. I can well fancy how great the favor of your hospital is and how grateful the Koreans are for it. I am sending you with this note some apples from Taiku which I request your acceptance of, hoping that you will taste them with your nurses."

HOW AMERICA MAY HELP BELGIUM AFTER THE WAR

A Message to This Country from a Member of the Belgium Mission on Industrial Management—A Permanent American Foundation in Belgium Suggested to Foster the Brotherhood of the Two Nations

BY CAPTAIN DR. RENÉ SAND, LECTURER IN SOCIAL MEDICINE, UNIVERSITY OF BRUSSELS, MEMBER OF THE BELGIAN MISSION ON INDUSTRIAL MANAGEMENT

NO one fails to see the obstacles which will stand in the way of reconstructing our industrial and economic life after the war. Three-quarters of a million Belgians are either with the army, or working in free Belgium, in France, in Holland, in England.

Seven million still remain in the invaded part of our country. American generosity and efficiency—although beyond praise—are unable to prevent their rations from being scanty. Tuberculosis is rampant. The children are arrested in their physical development. Infant mortality, owing to the shortage of milk, is exceedingly high. The birth rate has fallen to a fraction of the death rate. More than a hundred and twenty thousand men—one out of every fifteen adult males—have been deported to Germany; they are now either dead or permanently broken down.

To work would be to aid the German army; so the industrial population has remained idle for four years. The inhabitants have small gardens, on which they grow potatoes and vegetables. But their health is gone, their skill is gone, their habit of speedy teamwork is gone. The factories have been purposely destroyed, the machines sent to Germany; railways and roads will be left demoralized and wrecked.

The spirit is unbroken, and nothing will shake it. A nation which has during ten centuries revolted against foreign domination is not likely to be subdued in a few years. But with the coming of peace new difficulties will arise.

It is easy to remain united in a defensive war. Differences will arise as soon as reconstruction begins. It will be impossible to avoid altogether party prejudices, religious discussions, differences of language, conflicts of interests and of ideals.

Another danger lies in the intellectual isolation to which the Belgians have been subjected. They have scorned German books and periodicals, but no other literature is available for them. Like the handworkers, the brainworkers have patriotically chosen to remain idle, so far as the assimilation of new facts is concerned. Occupied Belgium has to live on itself and by itself. However, for reconstruction work, a wide outlook and an up-to-date knowledge are necessary. And will there not be, after such a restricted, compressed existence, an immense desire for relaxation, for self-indulgence, at the precise time when a stern spirit and a steady purpose will be needed?

Nothing is as tragic as a lost opportunity. Belgium will have a fresh start after the war;

she will have a chance to rebuild not only her villages and factories, but also the whole of her political, educational, civic and social life. This is such a rare event in the history of a nation that to let it pass unused or only half used would be a greater calamity than the war itself.

The first few months of peace will decide our future fate; either we shall slip down to haphazard ways and hasty patched-up solutions, or we shall rise to a system of competence, efficiency, and constructive reform. At that moment our convalescent nation will need material help, personal help—nurses, social workers—and advice.

Infant mortality, bad housing, occupational hazards, tuberculosis, alcohol, venereal diseases will be among the most important problems. This means a hard struggle against ignorance, vested interests, old careless habits; nothing short of a great educational campaign will foster in a physically weakened and economically ruined nation the strength required for such an immense effort.

To give us a lead in these matters America is especially well situated, as she possesses the genius of organization together with far-reaching views and generosity of purpose. Besides, the

assimilation of immigrants has made Americans familiar with this kind of work. The American Red Cross and the Rockefeller Foundation have already helped France on similar lines with greatest success, and the United States has become so endeared to the Belgian people that every American initiative is sure to be enthusiastically and gratefully accepted.

We could imagine no greater service to our country and no better way of perpetuating the brotherhood which has grown up between both nations than a permanent American foundation in Belgium. Its triple purpose would be to foster research, to offer information on reconstruction problems, and to maintain an educational campaign aimed at raising the standards of life in Belgium.

Nothing can be done now on these lines. The war has to be won first. But it is perhaps not premature to try to outline the work which will have to be taken up as soon as hostilities will stop, and which would come too late if it were to be planned and discussed after the conclusion of peace only. We were unprepared for war; let us be prepared for peace.

A CANADIAN CIVIL HOSPITAL'S PART IN WAR WORK

Response of Vancouver General Hospital to Request of Military Hospitals Commission-- Military Annex and Its Equipment a Gift From Citizens of the City and Province

BY MALCOLM T. MACEACHERN, M.D., C.M., GENERAL SUPERINTENDENT, VANCOUVER GENERAL HOSPITAL,
VANCOUVER, B. C.

SINCE war commenced many civil hospitals have altered their policy and line of extension and development, owing to the war, and extended their service along war lines and demands. One of the Canadian hospitals which has participated in the care of soldiers from the outset to the present is the Vancouver General Hospital, a well-established, well-organized, and well-equipped institution.

In the first year of the war this hospital opened its doors to recruits and many hundreds were fixed up for active service at the front. Shortly after this came the enlisted soldier, and for a long time a great number were treated in the wards of the hospital, where they were given use of all the civilian facilities, but kept mostly in a separate section of the hospital. Two years ago the Military Hospitals Commission of Canada asked the hospital to take care of three hundred returned wounded or sick soldiers, many of them cot cases. Previous to this the hospital had been caring for a smaller number of returned men, but it was felt that increased accommodation was needed on account of the rapid evacuation of

Canadian soldiers from all hospitals in England. However, the request of the Military Hospitals Commission was quickly complied with, and in the course of three months, accommodation for three hundred soldiers was arranged for in a comfortable and well-equipped annex to the Vancouver General Hospital. The building and equipment were a gift from the citizens of the city of Vancouver and the province. The excellent equipment was supplied through the efforts of the women of the city; the money for the building was raised by the business men. Both these organizations were very enthusiastic in their work, and seventy to seventy-five thousand dollars was raised in short order. The building was soon erected, equipped, and ready for patients, and since that time has been used constantly. This, possibly, has been one of the most successful and complete undertakings with which anyone could have the privilege of being connected, and showed distinctly the advantage of cooperative organization. The business men organized themselves into a financing committee and in a few days raised the money; the ladies of the city organized them-

selves into an auxiliary of about three hundred members, and with a capable and representative committee of management soon had the money for the equipment raised and all in hand. Everything

ment has always been a most harmonious one, and, indeed, general satisfaction and efficiency have been manifested.

The civil hospital finds that the military hospital does not interfere at all with it in its work. The extra staff needed was very simple. In the various departments throughout the main hospital a few extra help had to be added here and there and some additional equipment. The well-organized and established facilities very soon adapted themselves to the increase of two to three hundred patients. The civil staff of the military annex is as follows at present: Nurse in charge or supervisor of the nursing of the entire institution; each ward has the following staff: ward supervisor or graduate nurse, three or four ward helpers or attendants, two orderlies, one cleaner.

The nurse in charge does all the medication or



Fig. 1. The military annex of Vancouver General Hospital.

was done according to well-laid-down plans and standards, so that on completion there was nothing missing.

All equipment was of a standard nature, so that it could be used for further hospital purposes after the war was over.

The location of the building is about thirty feet from the end of the service wing of the Vancouver General Hospital. This meant easy access to civilian facilities, such as operating rooms, kitchens, x-ray, laboratory, etc., and had an economic advantage in saving expenditure of money in duplication of facilities.

The arrangements of the Vancouver General Hospital and the military annex are rather unique, inasmuch as the Vancouver General Hospital supplies the complete service, excepting the medical officers and the military officials needed for clerical work, discipline, etc.

This annex is used for active cases, whereas the splendid convalescent hospitals of Vancouver are close at hand and are under purely military management.

The hospital is, therefore, mostly civil in administration, though the medical officer resident is military, and deals directly with the general superintendent in matters arising out of civil details. The arrange-

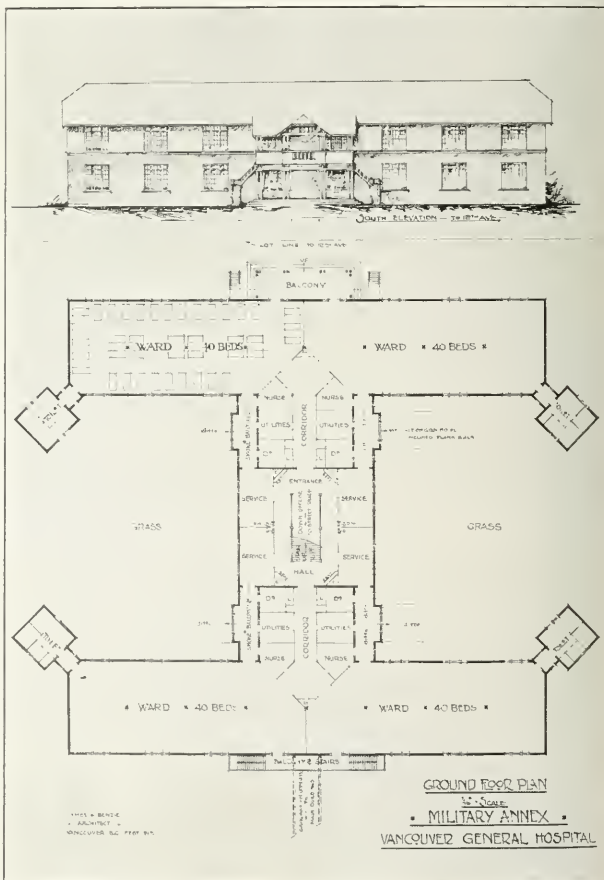


Fig. 2. Front elevation and floor plan of the Vancouver General Hospital military annex for returned soldiers.

treatment, whereas the ward attendants or helpers do all the bedmaking, dusting, tidying, etc., as well as carrying and assisting with the serving of meals. These are under direct supervision of the nurse in charge, and are paid a small salary for their services. They are not the so-called V. A. Ds, as they are girls that are working to a certain extent for the love of the work and content to take a living wage. This scheme has proved exceptionally successful, inasmuch as the general work of the ward is done very efficiently.

The orderlies do such work as is required of them in the civil hospital. We have had several military orderlies who are there for experience and training.

In addition, there is also a relieving nurse between the wards on each floor. In each ward there is a military officer known as the ward mas-

pital, inasmuch as different units can be devoted to different conditions.

The sanitary facilities are built out at the end in each case, with plenty of circulation and air roundabout. The nurse's office is so arranged that she has complete view of her ward at all times. In addition, there is a dressing room, doctors' room, linen room, sitting room and kitchen attached to each ward, making the unit complete. Since the erection of the building an



Fig. 3. A ward sitting room in the military annex.

ter or sergeant. So far as carrying on the work is concerned, with the staff as outlined there has been no difficulty.

By the accompanying plans it will be seen how very simple the layout is, but yet efficient to do the work. There are eight units, all having complete and separate service, each unit capable of caring for forty cases. This, we find, gives better service in such a hospital. Then again, if this building ceases to be used for military purposes, it can become a useful adjunct to the civil hos-



Fig. 4. A view in the wards of the military annex.

extensive solarium has been attached to the front, capable of holding a large number of beds at one time. The upper story is connected with the service wing of the civil hospital by a bridge, which gives direct connection to the main kitchen, and thus the food problem is readily handled.

Speaking from a civilian standpoint, there are several advantages in the scheme as carried out. First of all, it gives the returned wounded soldiers the opportunity of using the up-to-date well-established and well-organized facilities of the civil hospital as well as the service of an experienced staff, which it might take time to get under other arrangements.

Secondly, it saves the country a large amount of money by not having to duplicate facilities such as operating rooms, x-ray laboratory, kitchens and other costly facilities in hospital construction.

Thirdly, the citizens of Vancouver and a great many of the province have a more direct hand in war work, inasmuch as they have given freely of their funds and possibly a great many of them helped with their hands to carry on this work, giving each and all a more personal touch with the war as it is today.

Lastly, we have given employment to a large number of people who, though anxious to get over-

seas and do something at the front, are prevented from doing so for good reasons. We have always endeavored to take such people on our staff, for we find that those people have their whole heart in the work.

I am not going to speak for the military side of it, but all that I have heard has been commendable. I will say that, so far as discipline is concerned, from my observation I do not think that there could be any better anywhere than we are having.

Recently the Vancouver General Hospital has taken on some more war work, inasmuch as an arrangement has been made with the Invalided Soldiers Commission of Canada to set aside a por-

tion of the hospital for the treatment and care of the discharged returned soldiers who are being brought back to civil life. This latter class will, of course, gradually increase and finally be a large number.

In conclusion I want to apologize for this very short, hasty and somewhat disconnected description of our arrangement with the military department. The arrangements made here in the Vancouver General Hospital may be somewhat unique in themselves and somewhat more than have been made with other civil hospitals in Canada, but still I must conclude that so far they have been satisfactory, and I feel that efficient and good results have been obtained in all cases.

AN EFFICIENCY SYSTEM FOR THE MEDICAL WORK OF STATE HOSPITALS

Records That Are a "Second Memory" for Physicians—How the Clerk Can Help—Keeping Tab on Regular Duties and Happenings—The Purpose of the System

By H. DOUGLAS SINGER, M.D., M.R.C.P., STATE ALIENIST, DEPARTMENT OF PUBLIC WELFARE, STATE OF ILLINOIS.

THE work of the medical officer in a state hospital includes a very large proportion of routine which is very likely to include much that can be just as well performed by some non-professional worker. There is a great tendency to the occurrence of much waste of time, due to various causes, such as looking up previous records, waiting for a patient to be found for examination, filling in blanks, which is often a purely clerical procedure, being called away for visitors, etc. There is also a very serious liability that patients who stay in the institution for a long time will be overlooked. The records of examination upon admission are, as a rule, fairly complete, although even here omissions of some detail are not infrequent, but the notes upon the progress of the case are quite often sadly deficient.

In order to minimize these defects and relieve the medical staff of the necessity for remembering from day to day the routine duties to be performed, an efficiency scheme has been introduced into the Illinois state hospitals which has now been in force in one for about eight months. The system has been found to work very simply and satisfactorily and to have resulted in a marked improvement in the records and a great saving of the physician's time. It will also provide an objective basis for the estimation of the physician's efficiency, which will be valuable for determining promotion, and will afford a clear index of the size of the medical staff needed for the particular hospital. This last feature is of very great value, for this question has in the past been largely decided by guess or custom. The size of the hos-

pital is no real criterion of the size of the staff, and even the admission rate, which is a much more important index, will not settle the answer conclusively, as much will depend upon the type of patients being received.

MINIMUM REQUIREMENTS FORMING BASIS OF SYSTEM

The basis of the system is the establishment of certain minimum requirements for studying patients and recording the results. Such requirements can be modified at any time without materially altering the system. Those which have been adopted may be divided into two parts: (1) the examination on admission; (2) examination subsequent to this.

(1). Records upon admission. These must include the following points and must be completed within the times set:

- A. *Initial examination*, to be made within twenty-four hours. This is a superficial survey of the physical and mental condition, made with a view to obtaining a record of obvious facts and determining the immediate needs in the way of treatment or more exact study.
- B. *Anamnesis*, to be obtained as soon as possible. The time required may depend upon the ability to secure interviews with relatives and friends, and hence no definite limit can be set. Check of the visits from those capable of giving information is kept by the efficiency clerk, who will notify the doctor concerned when such opportunity occurs.
- C. *Physical examination*, to be completed within three days.
- D. *Dental examination*, to be completed within three days.
- E. *Urinanalysis*, to be made within three days.

- F. *Blood for Wassermann test*, to be taken within three days.
- G. *Vaccination*, to be done within three days.
- H. *Mental examination*, to be completed within seven days.
- I. *Presentation at a staff meeting*, to be made within ten days.
- J. *Summary* of all previous investigations with, if necessary, second presentation at a staff meeting, to be made in a period from three to six months. The decision as to the necessity for second presentation is made at the first staff meeting, and an approximate date for this is set. It can be changed with the consent of the officer responsible for the medical work of the institution. A case may be recommended for representation at any time by the physician in charge, if he deems it desirable.
- K. *Special points for further study*, requested during the discussion at the staff meeting, with the time at which they should be completed, will be noted at the time of the staff meeting and will be indicated to the efficiency clerk.

(2). Records subsequent to the first detailed examination (progress notes). The more acute cases require more frequent records. The frequency required as a minimum has been set as follows:

- A. *Acute mental wards*, every seven days.
- B. *Acute bodily illness*, every three days.
- C. *Subacute and convalescent cases*, every thirty days.
- D. *Custodial cases*, every six months.

The decision in which group a patient is to be placed rests with the clinical director or the officer performing this function. To a large extent this will correspond with the subdivision into wards, but in some instances, especially on the hospital for somatic diseases, there may be patients belonging in several categories, requiring notes, for instance, every three, seven, or thirty days. The rule is made that every patient sent to the hospital ward is placed automatically in the three-day group, and remains there until instructions to change this are issued.

METHOD OF KEEPING CHECK AND BLANKS USED.

1. *Personnel*.—One clerk is capable of keeping account of the examinations needed, and the work done for a hospital with two thousand to twenty-five hundred beds and having an average admission rate.

2. *Cards used*.—A. Figure 1 illustrates the front and back respectively of a card which is made out for each patient. At the left, on the face of the card, is printed a list of the routine examination requirements. The clerk enters in the adjacent columns the date when these were filled, and by whom. Under the heading, "Special Investigations," the clerk will write in any further investigation requested either at the staff meeting or by other means, and the dates when they are performed. At the extreme right are columns for the ward on which the patient is liv-

ing, with the date on which he went there. The clerk must be notified of all transfers, so that the proper grouping of the card can be made. The heading "group" above refers to the 3-day, 7-day, 30-day, or 180-day notes required for this patient.

On the reverse side space is provided for entering the dates on which medical or dental progress examinations are made, and further space for possible transfers.

These cards are filed under index cards as follows:

- (i) The main headings are: Reception, 3-day, 7-day, 30-day and 6-months.
- (ii) Subheadings: Under each of these main heads the names of the wards on which there are patients requiring examinations at these intervals.
- (iii) The cards are filed alphabetically under the ward names.

When a transfer is made, or the frequency of examination is changed, the clerk must remove the card from the group in which it is at the moment, enter upon it the name of the ward to which the patient has been sent, with the date or the new group in which he now belongs, and then refile under the new heading.

The clerk is also furnished with a list of the wards under the charge of each physician with the number of patients making up the service. He thus knows how many patients in each group must be examined by each physician, and divides the number of the frequency with which records are required. Thus, suppose a physician has on his service three patients in the three-day group, ten in the seven-day group and one hundred and fifty in the thirty-day group. In order to complete these, he must examine one of the first, one or two of the second and five of the third each day.

The names of the proper number are selected by the clerk and placed upon the card of physician's duties which is handed to him in the morning immediately after staff meeting.

B. Figure 2 shows above a copy of the physician's or dentist's duty card, and below that for the person in charge of the laboratory. Both are 3 by 5 inches in size. The efficiency clerk writes upon the physician's card the name and ward of the patient to be examined, and indicates by the following symbols the particular nature of the examination to be made: A, anamnesis; P, physical examination; M, mental examination; D, dental examination; S.M., to be presented at staff meeting; Sum, summary; P. N., progress note; C., correspondence; I. M., inspect meals; W. R., obtain blood for Wassermann reaction; L. P., lumbar puncture; Vac., vaccination. At the same time he notifies the ward to have the patient in readiness, and collects the records, if these are

not on the wards, and hands them to the physician with the duty card.

The routine urine specimens are ordered sent to the laboratory without the intervention of the physician, and at the same time any other clinical laboratory examinations which are required are entered upon the card for the laboratory. The number of specimens only is entered on these cards, which would otherwise have to be very large. A typewritten list of the names and wards of patients from whom specimens have been ordered is sent to the laboratory with the

Fig. 1. Front and back of the individual card made out for each patient. The original card measures 4 by 6 inches.

card. Similarly the person in charge of the laboratory enters upon his card only the number of specimens which have been examined, and returns the list of names with a check against those which have been done.

The physicians and dentist check upon the cards the examinations which they make and return the cards at the end of the day to the efficiency clerk, who enters the facts and date upon the cards of the patients concerned (Fig. 1). Should the physician perform any duty not entered upon his card, he writes the details upon the back of his card.

When a physician has charge of a service with the assistance of one or more of junior rank, the clerk makes out as many cards as there are medical officers, all of them containing the complete list of duties for the service. It is then the duty of the physician in charge of the service to allot the work for each of his assistants by crossing out all other duties and to give one such card to each assistant.

Duties not performed on any day will be added to those for the next day.

3. *Instructions concerning progress notes.*—The following set of instructions are given concerning what must be contained in notes upon progress:

- A. Facts which would tend to clear up questions raised at the staff meeting.

B. The condition of the patient at the time.

C. Any special happenings since last note (most of these will be recorded automatically from the daily report blanks, see Fig. 3).

D. Treatment which has been followed since last note. This will include occupations, re-education, etc.

In the case of the custodial wards the semi-annual notes must show:

A. The general physical condition of the patient as determined by actual examination.

B. Urinalysis.

C. Features which might lead to a reconsideration of the classification or of the opinions expressed as to the possibility of release.

D. Facts indicating any special requirements for treatment or dangers to be avoided not previously present or not recognized.

ADDITIONAL FEATURES

1. *Blanks.*—In order to provide for notice to the efficiency clerk of requests for special examination, transfers, etc., and at the same time to keep the superintendent informed of important happenings in the institution, the blank shown in

Fig. 2. Above, physician's or dentists' duty card; below, card for the person in charge of the laboratory. Each measures 3 by 5 inches.

Figure 3, made up in pads, is carried by each medical officer. Upon this blank the physician enters, during his visits to the wards, anything which may be of importance as to the condition of patients or wards, requests for special investigations (that is, red blood cell count, lumbar puncture, etc.) or even progress notes. At the same time, he places a check against the appropriate printed heading on the left.

These blanks are turned in to the efficiency clerk's office at noon each day, and are there sorted into groups, according to the heading checked. From these a daily summary or report is made by a stenographer for the information of the superintendent, the material being thus classified and grouped by wards. From this summary, there will be excluded those reports which con-

sist merely of progress notes or requests for special investigations.

All reports bearing upon the condition of patients will then be turned over to the clinical stenographer, who will copy them into the medical record of the individual patient. The stenographer will also, from these reports, make out any blank for reporting special incidents, such as injury to a patient, which may be required, and will submit them to the physician for his signature. The various records and reports are thus made automatically without further action on the part of the physician.

Critically ill	Name _____	Ward _____	Date _____
Sickness			
Symptoms			
Transfer			
Injury			
Assault			
Suicide			
Escaped			
Parole			
Discharged			
Death			
Administrative			
Progress Note			
Request for Treatment			
Signed _____			

Fig. 3. Blank to provide for notice to the efficiency clerk of requests for special examinations, transfers, etc., and also to keep the superintendent informed of important happenings. These blanks are made up in pads measuring 4 by 6 inches.

A report that a patient is critically ill, has escaped, or died, will also lead to a check upon letters or telegrams notifying relatives or friends, thus rendering more certain the performance of these highly necessary duties.

2. *Correspondence.*—All correspondence concerning patients requiring answer by a physician will go through the office of the efficiency clerk who will, each morning, enter upon the physician's duty card the names of patients about whom an inquiry has been received in the past twenty-four hours. The clerk will also collect the records of the cases, and hand them with the letters to the physician. This enables the latter to see his patient without having to make a special trip, and to collect the necessary information before answering correspondence. It also serves to keep check upon the promptness of replies.

3. *Visitors.*—The efficiency clerk will make appointments with all visitors who wish to see a staff physician, who sets apart a certain time in the day for such interviews. This has been found to effect a very great deal of saving of time for

both the physician and the visitors. The clerk will also have ready at such time the records of the case so that the physician may have available all necessary data.

COMMENTS

The system is devised, of necessity, only for the purpose of routine work. Emergencies must be met as they arise. In actual practice it has been found to result in a very great saving of waste time. Regular examinations of all patients have led to the detection of many unsuspected ailments, some of which might otherwise have resulted in sudden, unexpected death. In spite of the reduction in the size of the staff due to the war, more and better records are being obtained. It is also possible to see at a glance just how much attention has been given to any particular patient.

It has been found that the daily summaries of happenings in the institution are made out more promptly, and that they are rendered more useful by reason of the grouping which is part of the system.

The physicians have, in a few instances, been inclined at first to resent the introduction of the system, but, without exception, when they have realized what they are saved, and how they are enabled to devote themselves more fully to medical work and can arrange an orderly sequence of the day's duties, they have become enthusiastic for its adoption.

Heliotherapy and X-rays in the Treatment of Surgical Tuberculosis

Heliotherapy and x-ray treatment should be regarded merely as adjuvant methods in the conservative treatment of surgical tuberculosis, and not as substitutes for other methods of known and proved value. Sunlight has a direct action on superficial lesions, due to its bactericidal power, and an indirect action which produces favorable constitutional effects and benefits deeply seated lesions. Sandy and red-haired patients often show little pigmenting power, and the constitutional effects of the sunlight treatment are then lacking. Failure to induce pigmentation is often associated with latent tuberculosis even though all clinical signs are absent. The constitutional effects of sunlight are very marked. Metabolism and oxygenation are increased and the rate of respiration is diminished. Elimination is stimulated. Red cell formation, hemoglobin, and leukocytosis are increased. Heliotherapy in surgical tuberculosis is contra-indicated where pigmenting power is absent, in amyloid disease, and in certain acutely septic cases until improvement by other means has been effected.

X-ray treatment is most valuable in cases of tuberculosis adenitis, especially in conjunction with other methods of treatment. Its use is attended with danger in abdominal tuberculosis. It is also contra-indicated in tuberculosis disease of the genital organs.

The method is described by H. J. Gaurain in a recent issue of the *Proceedings of the Royal Society of Medicine*.



Fig. 1. The Ashland General Hospital, which has recently had an extension of three stories and basement.

A COMMUNITY HOSPITAL THE OUTGROWTH OF POPULAR DEMAND

The Ashland General Hospital, Built by an Association of Over Three Thousand Contributing Members, One of Two Institutions Supplying Hospital Facilities for a Community of Seventy Thousand

By J. M. DODD, M.D., SECRETARY WISCONSIN STATE BOARD OF MEDICAL EXAMINERS, ASHLAND, WIS.

THE Ashland General Hospital was the outgrowth of a popular demand and has succeeded beyond the fondest hopes of its founders. It began in the fall of 1916. An organization was formed and a campaign put on during the month of January, 1917, for \$40,000, under the direction of Mrs. Elizabeth Currier, which netted the proposed amount on schedule time, and another campaign a few months later added the sum of \$20,000.

The work of acquiring property then began with the purchase of the Wilmarth home, an old colonial structure, a model of architecture in its day, with ample grounds to provide for all future extensions. Provision was made to convert the building into a hospital until the necessary addi-

tion could be built for the hospital proper, and then use the old part for administration and the nurses' home. Twenty-four beds were placed in five rooms and the necessary hospital equipment was installed.

On June 12, 1917, the first patient was admitted and though, with the exception of one private room, only ward service could be provided, at the end of the first year 405 patients had been admitted.

Coincident with the acquisition of the property, plans were made for an extension 40 by 100 feet with basement and three stories. The basement was built last year. The accompanying sketches show the plans as made after consultation with various hospital authorities, including Dr.

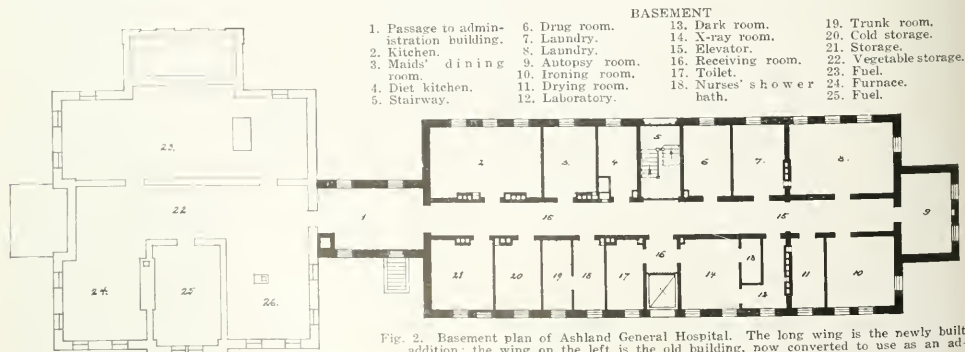


Fig. 2. Basement plan of Ashland General Hospital. The long wing is the newly built addition; the wing on the left is the old building, now converted to use as an administration building and nurses' home.

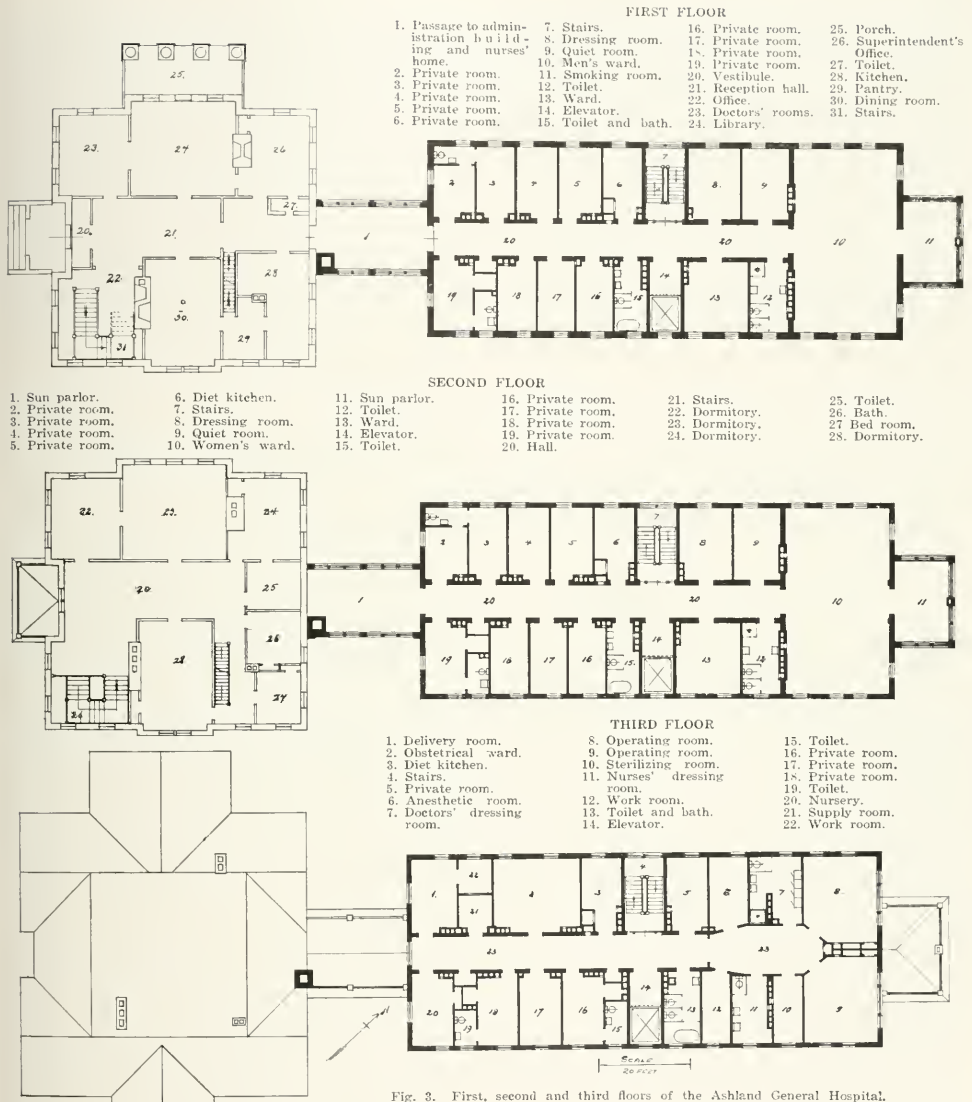


Fig. 3. First, second and third floors of the Ashland General Hospital.

Hornsby and Mr. Sturm of Chicago. The combined suggestions were worked out by the architect, Mr. Wildhagen of Ashland, and a very satisfactory arrangement of rooms and conveniences is the result. The new addition is well on the way to completion, and will be ready for patients about October 1. It will accommodate sixty beds, with room for considerable expansion in capacity, if necessary. The cost of construction of the new addition will be about \$60,000, and this has been

reduced considerably by having bought the brick and much of the building material last year.

The architectural design is attractive and in keeping with the style of the old building. The new structure is built of brick and reinforced concrete, the facing being a red paving brick with Bedford stone trimmings. Each floor, including that of the attic, is made of hollow tile and reinforced concrete. The stairs are of concrete and the partitions of gypsum plaster tile, making the

building fire- and sound-proof. The floors are to be of concrete, specially treated to make a smooth, non-absorbent surface. Conduit is laid in the floors for lighting, telephone, and silent signal systems. An automatic electric elevator will be installed. Stairways will be enclosed, and each room is provided with a ventilating flue. A sun parlor is located at the ends of the main corridors and just outside the large wards an orchard, a garden, and a small park make the grounds surrounding the hospital most inviting.

The hospital is one of two that supplies hospital facilities for a community of some seventy thousand people. It will be equipped and conducted in strict accordance with the best principles of

the healing art. It will have an organized staff of doctors, who will specialize in the various lines of practice. Already a training school for nurses is in operation under direction of a competent superintendent, and the prospect for the future of both the hospital and the school is especially bright.

It may be of interest to add that this hospital is being built by an association of contributing members of over three thousand, and we expect it to be supported by its earnings. An experience of thirty years in hospital work tells me this is possible, and it has been proved by the work we have done for over a year in the old building, where we have made an initial start with about five hundred cases.

HOSPITAL ACCOUNTING

Value of Classified Distribution of Expenditures—Administrative Expenses, Professional Care of Patients, Department, General House and Property, and Corporation Expenses

BY CHARLES A. PORTER AND HERBERT K. CARTER, OF THE STAFF OF THE MODERN HOSPITAL.

(Continued from September issue, p. 177)

DISTRIBUTION OF EXPENSE

EVERY hospital should be, and many are, required to make a classified distribution of all expenditures for each year for comparative and statistical purposes. These records are worth just what the management of the institution makes them as a basis for future operating and managerial policies and comparisons with other hospitals.

Cities that pay for the ambulance service of a hospital usually require the institution to keep an estimate of the cost of such service, the State for the care of compensation cases for which it pays, and the United Charities Funds associations for the cost of care of all free ward patients, on which they base their allowances to the hospital of funds collected by them. These figures are easy to obtain, and their value for comparative purposes is limited to the use made of them by the Superintendent and the Board of Managers of the hospital.

A complete system of cost keeping is more simple and accurate than results obtained by trying to separate certain specific costs from the whole list of expenditures, and the results obtained are of much greater value.

The managers and officers of the organizations to whom reports are made usually require a statement of the amount spent in corporation affairs—management of the hospital, professional care of patients, maintenance of buildings and equipment, and in the operation of the various departments of

the hospital. In addition to this, they should be shown the amounts expended for food, patients, staff, and help; for salaries and wages, drugs, medicines, and supplies of all kinds in more or less detail.

The Superintendent should go still further into the expenditures, so as to show what has been spent for each main division of the food supply, such as meats, bread, butter, eggs, milk, cereals, fruits, vegetables, etc.; each division of supplies for the various departments; for equipment, apparatus, and capital expenditures. To obtain such a distribution of expenses, it will be necessary to divide the hospital into its principal divisions, such as Corporation, Administration, Professional, Care of Patients, Departments, and General House and Property; then to subdivide these two main divisions, Departments and General House and Property, into their components, and to classify the expenditures of each of these groups and units.

In the next few pages is shown the method of classifying these expenditures in as much detail as will be necessary in the average institution, numbering the accounts so that they may be referenced in the Charge Register (Form 13) to the Invoice Jacket from which they are entered.

I. ADMINISTRATION EXPENSES

1. *Salaries (Officers' and Clerks').*—Includes the salaries of the general officers of the hospital, their assistants and clerks, whose salaries are not chargeable to any department or other main

group. Care must be taken not to include officers and clerks strictly engaged in the affairs of the corporation. If certain of these are spending part of their time in the affairs of the corporation, a proportionate part of their salaries should be so charged. This account includes the salaries of the Superintendent and his assistant, the accountants and clerks, cashier, purchasing agent, compensation clerks, stenographers, information clerks, etc.

2. *Stationery and Printing*.—The cost of the printing of annual reports, books, forms, charts, paper, stationery, and miscellaneous printed matter is included under this heading.

3. *Postage*.—The cost of all postage used in conducting business of the hospital is charged to this account.

4. *Telegraph and Telephone*.—Included in this account are all expenditures for telegraph service, including operators, toll charges, and maintenance.

5. *Legal Expense*.—This account includes all fees and retainers paid for services of attorneys and collectors, cost of suits, notarial fees, etc., expended in the operation of the hospital, but not those due to the cooperate business of the institution.

6. *Furniture and Fixtures*.—All expenditures for the purchase of furniture and fixtures purchased for the hospital and not chargeable to the corporation are charged to this account.

7. *Miscellaneous Expenses*.—Appearing under this caption are all expenditures for items not chargeable to any of the preceding accounts, including carfares, traveling expenses, subscriptions to magazines and periodicals, expressage, etc.

II. PROFESSIONAL CARE OF PATIENTS

8. *Salaries and Wages*.—This account includes the salaries and wages of doctors, superintendent of nurses, head nurses, nurses, orderlies, and others engaged in the care of patients, whose salaries or wages are not chargeable to any of the departments listed under that head.

9. *Apparatus and Instruments*.—Listed under this heading are the costs of maintenance of apparatus and instruments, but not that of new equipment, which is chargeable to capital expenditures. (See definition of Equipment and Supplies, page 103, August, 1918.)

10. *Equipment for Nurses and Orderlies*.—The cost of uniforms, books, and instruments furnished free of charge to the nurses and orderlies of the hospital are charged under this caption. (Articles for which the hospital is to receive payment should be charged to material account.)

11. *Medical and Surgical Supplies*.—The ex-

penses included in this account are for supplies purchased for the general use of the hospital not chargeable to the other subdivisions of professional care of patients, or to any of the departments.

12. *Dispensary*.—All salaries, wages, and medical and surgical supplies pertaining to the dispensary are charged to this account.

13. *Pathological Laboratory*.—Chemicals, salaries, wages, and miscellaneous expenditures of all kinds incurred for the pathological laboratory are charged to it.

14. *X-Ray Service*.—Salaries and wages, plates, tubes, and miscellaneous supplies are chargeable to this department.

15. *Social Service*.—Listed under this caption are salaries and wages, medical and surgical supplies, clothing, and miscellaneous expenses incurred for the visiting nurses and doctors.

16. *Emergency Ward*.—Salaries and wages, medical and surgical supplies, and miscellaneous expenses chargeable to the emergency ward are listed in this account.

III. DEPARTMENT EXPENSES

17. *Ambulance*.—This account includes wages, gasoline, supplies, repairs, and miscellaneous expenses incurred for the maintenance and operation of the ambulances.

18. *Meat, Poultry, and Fish (Steward's Department)*.—This account includes beef, mutton, veal, pork, ham, bacon, poultry, game, fish, and shellfish.

19. *Dairy Products (Steward's Department)*.—Milk, buttermilk, cream, cheese, butter, and eggs are listed in this account.

20. *Groceries and Provisions (Steward's Department)*.—Flour and cereals; bread and crackers; coffee, tea, cocoa, and chocolate; yeast and baking powder; sugar, molasses, and syrups; lard and other shortenings; spice and flavoring extracts; salt, pepper, and condiments; canned soups; canned fruits; canned vegetables, and other foods and food products are listed in this account.

21. *Fruits and Vegetables (Steward's Department)*.—Appearing under this caption are potatoes, apples, oranges, and lemons.

22. *Miscellaneous*.—This account includes salaries and wages, repairs, general supplies, ice, table water, and other items not chargeable to the steward's account and not included in the other four lists.

23. *Training School*.—Salaries and wages, supplies, and miscellaneous expenses are listed under this caption.

24. *Laundry*.—Included in this list are wages,

soap, starch, miscellaneous supplies, and repairs chargeable to the laundry.

25. *Housekeeping*.—This account includes salaries and wages and miscellaneous supplies.

IV. GENERAL HOUSE AND PROPERTY EXPENSE

26. *Heat, Light, and Power*.—All salaries and wages, fuel, oil, electric lighting, repairs, and miscellaneous supplies used by this department should be charged to this account.

27. *Maintenance of Buildings*.—Charge for labor, materials, general supplies, and miscellaneous expenses incurred in the maintenance of buildings should be charged to this account.

28. *Maintenance of Equipment*.—Salaries of mechanics and supplies. This account includes the cost of maintaining elevators, fans, refrigeration system, and other equipment, the charge to which cannot be distributed to any specific departments.

29. *Insurance and Taxes*.—The total cost of all building insurance, water taxes, etc., are included in this account.

30. *Rent*.—This account includes the cost of all buildings used for hospital purposes, except as a dispensary, laboratory, or the training school. Were the expenditure for one of these three mentioned, it would be charged directly to the department for which it was expended.

31. *Miscellaneous*.—Items that do not pertain to any of the accounts already given may be placed in the column for this purpose in the Charge Register and properly described.

V. CORPORATION EXPENSES

32. *Salaries (Officers' and Clerks')*.—Included in this account are the salaries of officers and clerks exclusively engaged in the management of the corporation, and the proportional part, if any, of salaries in the administrative offices which are chargeable to this account.

33. *Stationery, Printing and Postage*.—This account includes all moneys spent for stationery and printing used by the Treasurer for his books and that of the Campaign Committee for raising funds and postage for same.

34. *Legal Expense*.—All fees and retainers paid to attorneys, costs of suits, etc., which are chargeable solely to the corporation are included in this account.

35. *Interest*.—Interest on all notes and loans payable made by the Treasurer of the corporation should be charged to this account.

36. *Miscellaneous*.—In this account are all charges for miscellaneous corporation expenses, such as telephone, telegraph, car fares, and other items not chargeable to any of the four accounts above mentioned.

CURRENT EXPENSES FROM SPECIAL FUNDS FOR STATED PURPOSES

37. *Current Expenses from Special Funds for Stated Purposes*.—This account includes expenditures of all special funds held for stated purposes, and an itemized list should be shown.

CAPITAL EXPENDITURES

38. *Capital Expenditures*.—This account includes all expenditures for additional land, buildings, machinery and equipment, apparatus and instruments, and furniture and fixtures.

MATERIAL

39. *Material*.—All material purchased should be charged to this material account. (See definition, page 103.)

This distribution of expense is arranged in as much detail on the Charge Register as is made necessary by the volume of transactions falling under each of the accounts mentioned in the distribution of expenditures. All of these accounts may be shown on the Invoice Jackets. This distribution is indicated on the Invoice Jackets and Charge Register, so as to facilitate the gathering of the total amount spent for each class or subdivision of accounts and the total expenditure of each of the main groups mentioned in the distribution. Having gone this far, the expense analysis and budget systems, as later explained are easy to keep up.

INVOICE JACKETS

The Invoice Jacket (Form 14) shows the distribution of expenditures to be made in the Charge Register.

The classification of expenses into groups according to the data required by the United Hospital Funds Associations, State Boards of Charities, and the hospital itself for comparative and statistical information, as determined in distribution of expense, is shown on this form.

Every invoice, pay roll, and petty cash statement should have a jacket made out, showing the distribution authorized, attached thereto, and then entered in the Charge Register.

The Invoice Jackets, except those paid as made out, should be filed in a drawer, marked "unpaid bills," under the dates due. As they are paid they should be transferred to a file marked "paid bills" and arranged in numerical sequence. At the beginning of the following month some of these will need to be referred to in making out the Expense Analysis. After this report is completed, these jackets should be done up in packages of five hundred or any convenient number, a slip placed on the face of the package giving the

THE MODERN HOSPITAL			No. 1492			Am't \$ _____		
Favor of _____			Date _____			Terms _____		
DISTRIBUTION	AMOUNT	No.	DISTRIBUTION	AMOUNT	No.			
CAPITAL EXPENDITURES			TOTAL BROUGHT FWD.					
ADMINISTRATIVE EXPENSES			STEWARDS DEPT. CONT.					
Salaries & Wages			Confectionery + Ice Cream		19f			
Stationery & Printing			Lard etc		19g			
Postage			Spices + Flavoring Extracts		19h			
Telephone & Telegraph			Salt, Pepper + Condiments		19i			
Legal Expense			Canned Goods		19j			
Furniture + Fixtures			" Fruits		19k			
Miscellaneous			" Vegetables		19l			
			Fruits + Vegetables		20			
			Potatoes		20a			
PROFESSIONAL CARE OF PATIENTS			Miscellaneous					
Salaries - Supt. Nurses		8a			21			
Head Nurses		8b	Ambulance S.W.		22a			
Special Nurses		8c	Supplies		22b			
Nurses		8d	Repairs		22c			
Orderlies		8e						
Uniforms - Staff +		10	Training School		23			
Apparatus + Instruments		9	Laundry		24			
Medical or Surgical Supplies +		11						
Dispensary - Salaries		12	Housekeeping		25			
Medical or Surgical Supp.		12a-b						
Pathological Laboratory +		13	GENERAL HOUSE & PROPERTY					
Supplies		13a	Heat, Light + Power		26			
X RAY S. & H.			MAINTENANCE BUILDINGS					
Supplies		14			27			
SOCIAL SERVICE - K + H S + H			MAINTENANCE EQUIPMENT					
Medical Supplies		15a			28			
Surgical Supplies		15b	Insurance or Taxes		29			
Clothing		15c	Rent		30			
			Miscellaneous		31			
Emergency Ward S + H			CORPORATION EXPENSES					
Medical Supplies		16a	Salaries		32			
Surgical Supplies		16b	Stationery, Printing, Postage		33			
			Legal Expenses		34			
			Interest		35			
			Miscellaneous		36			
DEPARTMENTAL EXPENSES								
Stewards Dept. S + H +		17	CURRENT EXP. FROM SPECIAL FOLS.					
Meat		17a			37			
Poultry		17b						
Fish		17c	MATERIAL		38			
Dairy Products - Milk		18a						
Butter		18b						
Cream		18c						
Cheese		18d						
Eggs		18e						
Groceries - Flour + Cereals		19a						
Bread + Crackers		19b						
Coffee, Tea, Cocoa, Chocolate		19c						
Yeast, Baking Powder, etc.		19d						
Sugar, Molasses + Syrups		19e						
TOTAL FORWARD			TOTAL					

Form 14. Invoice Jacket. Actual size, 8 by 3 1/4 inches.

dates and numbers of the jackets included, and sent to the vaults for safekeeping.

These Invoice Jackets are not used as vouchers because the form of check used is a sufficient legal receipt in itself.

PAY ROLL AND TIMEKEEPING

The Pay Roll (Form 16) is best kept in a loose-leaf binder, using a sheet for each department of the hospital, such as Administration; Emergency; Dispensary; Heat, Light, and Power; Professional

Care of Patients; Domestic; Steward's Department, and General.

Administration includes Superintendent, Assistant Superintendent and clerks, purchasing agent and clerks, receiving clerk, information clerks, accountant and clerks.

Emergency Pay Roll includes emergency nurses, surgeons, orderlies, etc.

Dispensary Pay Roll includes all those people whose services are used by the Dispensary, as clerks, doctors, surgeons, nurses, etc.

Heat, Light, and Power Pay Roll includes engineers, assistant engineers, firemen, oilers, elevator runners, mechanics, and others assisting in the maintenance of buildings, heating, lighting, etc., and may include ambulance drivers.

Professional Care of Patients' Pay Roll includes superintendent of nurses, head nurses, orderlies, medical and surgical services, dietitians, and all others engaged in assisting the care of patients.

Housekeeping includes housekeeper and those under her supervision.

Steward's Department includes storekeeper, chef or cook, kitchen help, and all others engaged in preparing or assisting in the preparation and delivery of food.

General Pay Roll includes all those who have a department where but one or two are employed, as pathologist, chemist, and radiographist.

The Pay Roll should show the rate per month of those employed by the month and the rate per hour of those employed by the hour. There should be columns for total pay, deductions for advance payments, net pay, time check numbers, dates, and remarks.

The best way to obtain information for making up the Housekeeping Pay Roll is by use of a time clock placed under the watchful care of the Assistant Superintendent or Matron. Regular time books may be used by the head of each department

may be given brass checks, bearing their number, at time of employment, and these are to be presented to the paymaster and returned with their pay.

A form of Time Check (Form 15), to be used

PAYROLL										Period Ending	Approved	Signature
DEPARTMENT												
OPERATORS			TIME		TOTAL		DEDUCTIONS		NET PAY		TIME CHECK NO.	
NO	NAME	OCCUPATION	RATE	DAYS	HOURS	EARNINGS						REMARKS

PAYROLL						Period Ending	Approved	Signature	
TIME		TOTAL		DEDUCTIONS		NET PAY		TIME CHECK NO.	
DAYS	HOURS	EARNINGS							REMARKS

Form 16. Pay roll. Kept in loose-leaf binder, with binding margin to be added at left-hand side. Actual sizes, upper sheet, 12½ by 11 inches; lower sheet, 9 by 11 inches.

when settling up with help at any and all times in advance of the Pay Roll date, is shown. These are paid out of the petty cash fund, and, as a check is drawn to cover the Pay Roll fully, the amount left over after filling the envelopes should equal the total amount shown by these time slips and be returned to the fund and slips removed.

[To be continued]

A Few Civil War Hospitals.

In December, 1864, the United States had in active service 192 general and special military hospitals with a capacity of 118,000 beds. In Washington alone were 25 hospitals with 21,426 beds. When the Civil War broke out hospitals had to be improvised. Churches, college buildings, factories, hotels, etc., were converted into hospitals. Later in the war a great number of hospitals were erected on the pavilion plan. The pavilions, long, low one-story structures, provided with the so-called "ridge" ventilation, were connected by a covered corridor. In the Hicks Hospital in Baltimore, the covered corridor had the form of a semicircle from which the 18 pavilions radiated in all directions, while the administration building was placed in the centre of the circle. In the Lincoln Hospital at Washington, the pavilions were arranged *en échelon* in the shape of a V, the inner ends being connected by a continuous covered corridor. As the war advanced many improvements were made in the construction of the hospitals, especially with regard to lighting, heating and ventilation. The covered and closed corridors of the earlier hospitals were later replaced by corridors entirely open on the sides.

These hospitals are described by Lieut.-Col. C. Wood in a recent number of the *Military Surgeon*.

Golden friendship is not a common thing to be picked up in the street. It would not be worth much if it were. Like wisdom it must be sought for as for hid treasures, and to keep it demands care and thought. To think that every goose is a swan, that every new comrade is the man of your own heart, is to have a very shallow heart. —Hugh Black.

TIME CHECK - NOT NEGOTIABLE		No.
The MODERN HOSPITAL		
Date 191		
Debit	Name	No.
Occupation	Debit	Occupation
Rate	Time	Rate
Amount	Amount	700 Dollars
Issued to:	Time given under Name	
	Received Payment in full	
Amount	By	

Form 15. Time Check. Actual size, 6 by 3 inches.

if desired. Great care should be taken in registering overtime.

Particular attention is called to the Pay Roll (Form 16), which has been designed with a view to saving time.

Forms ordinarily used require the signature of the payee, but this is not necessary, as it neither prevents padding nor shortages caused by error.

Every employee should be numbered, whether time clocks are in use or not. The pay is placed in envelopes bearing these numbers, and all employees are required to give their name and number when calling for their pay. Domestic help

THE DEPARTMENT OF LABORATORIES

Construction of Laboratories Ordinarily Given No Expert Consideration in Building of Hospitals—Organization, Director, Budget, Routine, Record-Keeping, Research, Etc.

By MAX KAHN, M.A., M.D., Ph.D., DIRECTOR OF LABORATORIES, BETH ISRAEL HOSPITAL, NEW YORK CITY.

"Vere scire est per causas scire—To know truly is to know through causes—and he is the scientific physician or surgeon who seeks and determines causes; for only when the cause is deduced can treatment be rational." (Adami.)

IT is a curious and surprising fact that, in the building of hospitals, the construction of the laboratory department is given no expert consideration. Usually after the hospital has been completely erected, certain space, unsuitable for any other purpose, is assigned to the laboratory. It is thus that we find this department frequently located in basements, in out of the way nooks and corners, in outhouses or roof structures built as an afterthought. The laboratory is gloomy, the ventilation unsuitable, and the general conditions such as to make the scientist working there cognizant of a spirit of depression in his assistants and help. It is only, it seems, an Epimetheusian consideration which prompts the hospital authorities to build adequate quarters for the laboratory. Thus we see some of the largest hospitals in the country, erected and equipped for all work (except the most important), and getting along for some years with a makeshift diagnostic laboratory until, finally, either adjacent ground is bought and a laboratory building erected, or an additional floor is built on the roof, or some other arrangement is made to house the scientific department.

The usual architect who draws the plans of a hospital—I have seen several such plans—is aware that the establishment is to have laboratory quarters, and he devotes some space to what he calls a "urine room" and a "pathological laboratory." The average superintendent of the hospital is able to point out to him how much space is to be devoted to the kitchen, to the scullions' chambers, to the steward's department, and to the doctors' recreation room, but he has not the knowledge to instruct the architect what the requirements of the laboratory department are. If space is lacking, it seems always proper to cut off some of the space devoted to the so-called "urine room" and use it for any other more urgent purpose.

So far as the laboratory department is concerned, the hospital authorities do not seem to learn from the mistakes of their neighbors. It takes several generations of laboratory directors, who, dissatisfied with the cramped, unsanitary

quarters, are always protesting and pleading for better surroundings, to influence and persuade the board of trustees to devote money to laboratory extension. The lay board, and sad to say, the average medical board, judge the value of a laboratory department not by the experiences of other hospitals, but by the work done by their own laboratory staff. If the scientist in charge is a capable, energetic, and learned man, and if, in addition to these qualities, he has much tact, it is usually possible for him to obtain a hearing. Experience shows, however, that the first and second succeeding laboratory directors resign in a dudgeon, and the authorities are compelled to grant certain inducements to the new man, who, taking a lesson from the history of his predecessors, controls his temper and allows the influence of time and the suasion of his work to obtain for his department its just dues.

It does not seem to occur to the trustees to build a fully equipped laboratory and judge the scientist by his work, dismissing him if he is incapable or inefficient. On the contrary, they always judge of the abstract value of a laboratory department for the hospital by the efficiency of the man in charge.

May I take the liberty in the following pages of discussing the question of the department of laboratories, and point out to the lay executives certain matters which appear very important to the scientist in charge of the laboratory?

It must be definitely understood that the twentieth century hospital must have a laboratory—not a makeshift, two by four, "urine room," not a gloomy, unventilated, poorly cleaned cranny, but well-constructed, properly lighted, scientifically equipped quarters. A hospital has been defined as a hotel with an operating room and laboratory attached. It is just as improper to have an inadequate laboratory as a dark and dirty operating room.

It is questionable whether the patient gets anything more than hotel comforts from a hospital having a poor laboratory. It is in the laboratory mainly where accurate diagnosis is made. Without laboratory confirmation, no diagnosis is certain. It is true that in many instances the laboratory serves but to make an accurate post mortem diagnosis. But it is futile to treat a patient the cause of whose disease has not been

determined. *Vere scire est per causas scire*, said Bacon. It is only groping in the dark to prescribe therapy for an unknown complaint.

The lay patients do not know of the tremendous amount of work that the hospital laboratory does or should do for them. They are aware that somebody must be cooking for them, that somebody is cleaning and washing for them. They see the surgeon dramatically and sometimes melodramatically impressing them with the delicacy of the operation. But they are not aware—they can not be aware—of what goes on before the operation is recommended. How many and various and difficult are the tests made before a diagnosis is possible! Nor does the rare melodramatic surgeon deign to inform the lay patient that the gall-bladder which he removed as being the cause of all evil has been reported normal by the laboratory. The patient, not knowing better, is minus a gall-bladder and minus a fee, but he still ventures to complain of pain in the same place and with the same insistence. In the medical—in contradistinction to the surgical—ward the laboratory is called on to do more work. It is called on to study the secretions and excretions, to analyze the various fluids of the patient, and to inform the physician in charge what the result is. Treatment, in so far as it can do good, is nowadays directly proportional to the amount of laboratory work. Given the diagnosis, it is a simple matter to treat—if treatment is possible—any case. The rub is in ascertaining the diagnosis.

I wish to discuss very briefly the laboratory question under the following headings: (I) organization; (II) the laboratory director and the medical staff; (III) the budget; (IV) the routine system of running the laboratory; (V) the record-keeping of the laboratory; (VI) the research work of the laboratory.

THE ORGANIZATION

I sometimes wonder whether a small hospital is a boon. It is true that the patient is sheltered from the cold and is given his meals in such a hospital, but besides this little is done for him. There is usually no laboratory department—I refer to the small, provincial hospitals—and the physician blunders along, as best he can, without scientific aid, as did the physicians of the by-gone centuries.

A hospital having more than two hundred patients should have a well-equipped pathological laboratory, bacteriological laboratory, biochemical laboratory, and serological laboratory.

The various laboratories should be in charge of men especially trained in their respective professions. It is unusual to find a man well studied in

two or more of the sciences, and to permit one man to take charge of the work of all the departments is to invite errors and mediocrity in those branches with which he is but superficially acquainted. It may be advisable to have one man as chief of the laboratories with assistants in the various other laboratories; or it may be well to have all the laboratory men on equal footing. It is usual to have the bacteriologist or the biochemist do the serological work.

The pathological department should have four rooms devoted to it. There should be: (a) an autopsy room, which should be rather large, and arranged, if possible, like a small amphitheater so that autopsies could be performed before the hospital staff, and the findings discussed, and equipped with the most modern table with running water and drainage; (b) a microtome room, where the pathological specimens are sectioned and stained; (c) an examining room, where the pathologist has his office, keeps his record and examines the specimens microscopically; (d) a dark room for photographic work. The pathologist should have at least one assistant and a technician helping him.

The bacteriological and serological department should have six rooms: (a) a cleaning and sterilizing room, where the glassware is washed and sterilized, and where mediums are prepared, in charge of one technician and a porter; (b) a bacteriological incubation room, where the organisms are incubated and the slides stained; (c) a bacteriological examination room where the microscopical work is done and the records kept; (d) a serological room, where the Wassermann and other complement fixation tests are performed; (e) a reception room, where patients wait to have their blood taken, etc.; (f) a transplant room, where inoculations from one medium to another are made. The bacteriologist should have one trained assistant and one technician helping him.

The biochemical department should consist of five rooms: (a) the chemical laboratory, where the analyses are made; (b) a hood room, where digestions involving the formation of fumes and odors are performed; (c) a titration and balance room; (d) consultation and record room; (e) a dark room for polariscopic work. The biochemist should have one assistant and one technician.

There should be, in connection with the laboratory, a museum, a general record room, a general library, a general store room, and an animal room, which should be roomy, light and well-ventilated. A porter should be assigned to the cleaning of the animal room and of the laboratory as a whole.

II. THE LABORATORY DIRECTOR AND THE MEDICAL STAFF

Properly to avoid friction between the physicians and the laboratory department, it is essential that at least one member of the laboratory staff should be represented on the medical board. In this wise all criticism could be directly answered, and all complaints explained or investigated. It seems unjust to the laboratory man who has spent more time to study his profession and who receives less material reward in the pursuit of it, to be treated like an educated employe by the other visiting physicians. It appears a characteristic trait of physicians to lay the blame on the laboratory department when things do not go well with their patients, and often undeserved censure is flung on the laboratory. With the presence of the laboratory representative on the staff, the needs of the scientific department could be better urged and the improvement suggested more impressively defended.

III. THE BUDGET

The laboratory is a source of expense to the hospital. So are the culinary department and the laundry. The laboratory is just as essential as are the other two departments.

Curtail the expense of the culinary department and everybody is dissatisfied. The patients will complain, as well as the doctors, the nurses, and the help. They are soon made aware that their inner selves are not as well suited as previously. Reduce the expense of the laundry and hygiene suffers. Cut down the expense of the laboratory department and conscience is outraged.

If a hospital has many private patients, it is proper that they should be charged an initial extra fee of five or ten dollars to insure that all laboratory work will be done without further charges. This, of course, can be done in such hospitals as have full-time laboratory men in charge of the various departments. In one hospital in Pittsburgh, about fifteen thousand dollars are annually collected from a five-dollar charge to each private case.

Generally speaking, a large hospital is to expect an expenditure of 4 to 5 percent of its budget for laboratory work. In certain hospitals, where men work on part time and their compensation is correspondingly diminished, the laboratory expenses are, of course, proportionately less. In those hospitals which charge a nominal fee for laboratory work to each private patient, and where the laboratory staff is on a whole time basis, the budget for the laboratory may be reduced to about one percent of the total operating expense of the hospital.

IV. THE ROUTINE OF THE LABORATORY

For the proper and conscientious examination of all specimens, all the analyses should be made by the laboratory staff either personally or under their supervision. All the routine urine examinations, blood counts, nose and throat cultures, sputum examinations, etc., should be made in the laboratory proper and under the direct charge of the laboratory man. To have ward laboratories where the interns make the examinations at their sweet pleasure is to invite slovenliness, inefficiency, and inaccuracy in all the routine examinations. I do not mean for a minute that the interns should do no laboratory work. I mean—and I am convinced after many years' experience—that the intern staff should be assigned for a certain period of their stay in the hospital to laboratory work, say one-sixth of their time. During this period they would do, under the guidance and with the assistance of the trained workers, all the routine examinations. If several interns spend their time in the laboratory simultaneously, they could be assigned to the various departments for a portion of their time, helping each other out when one man's work gets too heavy.

The method of procedure would be as follows: All the specimens would be sent to the laboratory before nine o'clock in the morning. All requisitions for blood counts, etc., would also be sent at the same time. The man assigned to urine work or culture examination, etc., would find all his specimens waiting for his analysis. The intern assigned to blood count work would proceed to the various wards with pipettes, etc., and take the blood for the count.

Certain days of the week should be assigned to Blood Chemistry, other days to Gastric Analysis, etc. On these days the intern would pass the stomach tubes on the various patients and bring the specimens to the laboratory. Wassermann tests are usually done twice weekly.

Of course, emergency work will be done at all times. One intern should be assigned in successive order to emergency night work. In this way all contingencies can be met.

V. THE RECORDS

All hospital laboratories keep records of the work that they do, but in many cases these records are incomplete and not get-at-able. The following system has proved satisfactory:

All original reports are made on the requisition slip. This should be done in ink and should serve as the permanent record of the work done. These requisitions with the report are sent to the laboratory typist, who stamps them in numerical succession. An index card is made out for each

patient, and all the requisitions are entered here, so that one can at any time locate all the laboratory work done for any patient, as shown in the illustration.

The typist then proceeds to make three type-written copies of the original report. One copy is sent to the house physician or surgeon, another copy is filed under the test performed, and a third copy under the name of the disease. Thus, if a phenolsulphonephthalein test is made on John Doe, who is suffering from kidney stone, the original report is filed in numerical order and the number indexed on the index card. One type-written report is sent to the physician, the second copy is filed under the word "Phenolsulphonephthalein," and the third copy under the word "Nephrolithiasis." Such records would be complete and would serve as a means to teach us the

BETH ISRAEL HOSPITAL DEPARTMENT OF LABORATORIES			
INDEX	NAME	WARD	ROOM
	Mr. John Doe	A	4
DIAGNOSIS	Renal Stone		
DATE	Feb. 2, 1918	SPEC.	Urine No. 3150
DATE	" 2	SPEC.	Blood Count No. 8124
DATE	" 3	SPEC.	Chemistry No. 8215
DATE	" 4	SPEC.	Wassermann No. 8306
DATE	" 4	SPEC.	Comp. Fix. Ix. No. 8317
DATE	" 5	SPEC.	Urine Culture No. 8470
DATE	" 5	SPEC.	Sputum No. 8486
DATE	" 6	SPEC.	Phen. sulf. phth. No. 8492
DATE	" 6	SPEC.	Urine from kidney No. 8571
DATE	" 7	SPEC.	Urine No. 8627
DATE	" 9	SPEC.	Blood Count No. 8811
DATE	" 12	SPEC.	Pathology No. 9032
DATE	" 14	SPEC.	Chem. of Stone No. 4327

Individual index card for laboratory work on each patient.

value of our findings with certain tests in various diseases. After several years had passed, the records would prove invaluable.

VI. RESEARCH WORK

Very few capable men will wish to have anything to do with a laboratory in which research work is interdicted. It is upon his research work that the reputation of a laboratory worker depends. His future career and his present contentment are in the work that he loves. To fail to encourage him in this work is to ruin the morale of the laboratory and usually means the resignation of the laboratory scientist. The reputation of the whole hospital is enhanced by the publication of the scientific researches conducted in its laboratory, and the whole medical staff should insist that research problems be investigated there, for the lay board is not aware of its great importance.

The executive head of the hospital may sometimes not be in sympathy with research work. Usually the superintendent, if he is broad-minded and cultured, will be the most enthusiastic in the

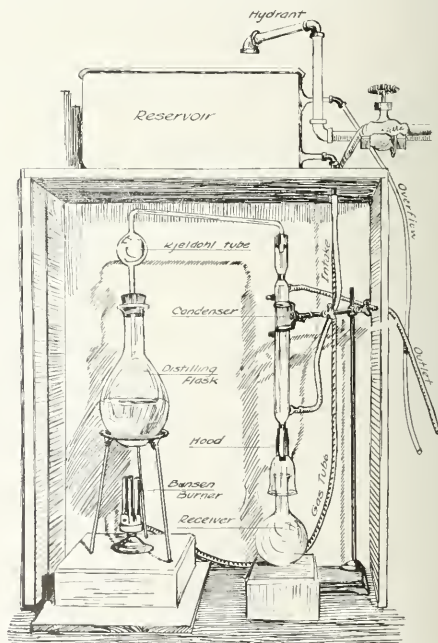
encouragement of original investigations. On the other hand, there are certain executives who are trained only in economics and discipline, and who can not discriminate between the higher scientific services of a laboratory and those of the mediocre type. Time, however, teaches them their lesson, for it is, I believe, difficult to find a scientist who would be willing to forego all the interest that the science has for him in delving in the unknown for the discouraging routine work. It is like taking out the spices and condiments from a meal, for research work is the spice of the laboratory worker's life.

Inexpensive Apparatus for Preparing Distilled Water

By ASA S. BACON, Superintendent, Presbyterian Hospital of the City of Chicago.

Freshly distilled water is coming more and more into demand by our physicians, for preparing salvarsan, physiological salt solution and other solutions for intravenous use.

The cut shows an inexpensive apparatus that is used in the Presbyterian Hospital, which is adequate to keep the



A simple and inexpensive device for the preparation of distilled water.

hospital supplied with freshly distilled water. Water from the hydrant flows into the reservoir and, by gravitation, through the intake. This reservoir is important, for it relieves the pressure on the condenser and prevents breaking. The overflow pipe prevents overflowing of the reservoir.

The apparatus is very simple and easily installed. Its parts can be purchased from any laboratory supply house.

THE VOLUNTEER MEDICAL SERVICE CORPS.

An Authoritative Statement of Its Plans and Scope—Reasons Why Every Legally Qualified Physician Should Enroll—Some of the Salient Features of the New Organization.

BY COLONEL FRANKLIN MARTIN, M.D., CHAIRMAN MEDICAL BOARD, COUNCIL OF NATIONAL DEFENSE.

The hospital organizations of the United States should be deeply interested in the Volunteer Medical Service Corps; first, because already many of their leading physicians and surgeons have been called to service in the Army or the Navy; and second, because a considerable percentage of additional members of the staff will be required within the next year to fill the new quotas necessary to fill the ranks of reserve officers in the Army, Navy, and Public Health Service.

Every member of every medical staff of every hospital who is not in service should now register in the Volunteer Medical Service Corps. Even those who are under forty-six years of age and in the draft should avail themselves of the advantages this Volunteer Medical Service Corps offers.

While ultimately forty per cent of all doctors of the United States will be asked to serve their government in uniform either in the Army, Navy, or Public Health Service, the other sixty per cent will be required to care for the enormously expanded work of the home territory. This means that more and more of the work at home must be concentrated in the existing hospitals, where under systematic organization the patients can be cared for in the greatest number, in the most scientific way, in the shortest time. The Volunteer Medical Service Corps wishes to have under enrollment every one included in the sixty per cent of the entire medical population who is not in military service, in order that the organization may aid in the proper distribution of doctors for home service, including hospitals, medical schools, war industries and home communities.

The corps also gives every medical man of the United States an opportunity to volunteer his services for any work that may be required of him by his government in this time of need, under circumstances that will obtain the best possible efficiency and inflict as little hardship upon the individual and the community as possible.

In the following paragraphs an effort is made to answer inquiries in regard to the purpose, scope and organization details of the Volunteer Medical Service Corps.

The Volunteer Medical Service Corps is an organization which provides means for obtaining quickly men and women for any military or civil medical service required in the war emergency. It furnishes recommendations and necessary credentials to assure the best medical service, both military and civil. It determines beyond question the attitude of the individual toward the war.

THE VOLUNTEER MEDICAL SERVICE CORPS

First authorized by the Council of National Defense on January 31, 1918.

Final reorganization on August 5, 1918, by the authority of the Council of National Defense, including confirmation of its Central Governing Board.

On August 12, 1918, the Volunteer Medical Service Corps was approved by the President of the United States, who said, in a letter to Dr. Franklin Martin, Member of the Advisory Commission of the Council of National Defense and Chairman of the Council's General Medical Board:

"I am very happy to give my approval to the plans which you have submitted, both because of the usefulness of the Volunteer Medical Service Corps and also because it gives me an opportunity to express to you and through you to the medical profession, my deep appreciation of the splendid service which the whole profession has rendered to the nation with great enthusiasm from the beginning of the present emergency."

Upon request to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C., application blanks and circulars of information will be sent. When received, the application form should be filled out completely, in accordance with instructions contained in the circular of information. The application should then be mailed to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C.

Every legally qualified physician holding the degree of Doctor of Medicine from a legally chartered medical school without reference to age or physical disability is eligible for membership, provided he or she is not already commissioned in the government service.

Eligibility is determined upon information obtained from application blanks, three personal references and the Executive Committee of the state in which the applicant resides. Based upon the information thus secured, the Central Governing Board will finally pass upon applications.

This corps is not authorized to bestow rank. Arrangements for compensation will be made between a member requested to perform a specific duty and the agency requesting service. The matter of compensation and place of service, whether with or without rank, must be determined at the time said request is made. When a member of the corps accepts service in the Medical Reserve Corps of the Army, Naval Reserve Force, the United States Public Health Service or any governmental department, he or she will be accorded the rank and pay incident to the service in the department in which he or she has enrolled.

No member will be *ordered* to render any service. Requests to perform specific duties according to qualifications and availability under the classification of the Volunteer Medical Service Corps will be made from time to time as emergencies arise.

The probable character of this service will be: (a) Medical Reserve Corps; (b) Naval Reserve Force; (c) United States Public Health Service; (d) American Red Cross; (e) Local and medical advisory boards; (f) Institutional (medical schools and hospitals); (g) industrial plants; (h) Civil communities (caring for civil communities, stripped of medical attention; caring for practices of physicians in military service; reclamation of registrants rejected for physical unfitness; services to needy families and dependents of enlisted men); (i) miscellaneous service.

If members of the corps are called to active military or naval service, the order in which they will be called will be:

(a) Physicians eligible for military duty but not enrolled.

(b) Physicians under fifty years of age without obvious physical disability which is disqualifying, and with not more than one dependent in addition to self (Class I of the Volunteer Medical Service Corps), will be the next to be called upon for actual war service. Any physician under fifty-five years of age who is without an obvious physical disability which is disqualifying and whose dependents have an income sufficient for the support of dependents other than that derived from the practice of his profession, may be called upon to enroll in the Medical Reserve Corps of the Army, the Naval Reserve Force, or the United States Public Health Service, when in the opinion of the respective Surgeons General his services are needed.

(c) Physicians under fifty-five years of age without obvious physical disability which is disqualifying and with not more than three dependents in addition to self (Class II of the Volunteer Medical Service Corps) will be the next to be called upon for active military or naval service.

(d) The next group advised to enroll for active duty with the Army, Navy, or Public Health Service (Class III), will be the physicians under fifty years of age who

are without obvious physical disabilities which are disqualifying and with not more than three dependents in addition to self.

The exceptions in the groups of physicians are as follows: (a) those essential to communities; (b) those essential to institutions (medical schools and hospitals); (c) those essential to health departments; (d) those essential to industrial Governing Board on recommendation of advisory boards.

The exceptions will be determined:

(a) *Essential to Communities.*—Essential community need will be determined by the Central Governing Board on recommendation of representatives of the Central Governing Board appointed by the Central Governing Board to make a survey of local conditions.

(b) *Essential to Institutions.*—Essential institutional need will be established after conference between representatives of the Central Governing Board of the Volunteer Medical Service Corps and representatives appointed by the governing bodies of the institutions concerned.

(c) *Essential to Health Departments.*—Essential health department need will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps, and representatives of health departments.

(d) *Essential to Industries.*—Essential industrial need will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps, and accredited representatives of industries involved.

(e) *Essential to Local and Medical Advisory Boards.*—Essential local and medical advisory board needs will be determined after conferences between representatives of the Central Governing Board, Volunteer Medical Service Corps, and representatives of the Provost Marshal General's Office.

Physicians not classified for actual military or naval service may, when emergency arises, be called upon to perform duties in accordance with their qualifications and merits, indicated by information contained in their application blanks. Those to be called for this service comprise: (a) Physicians over fifty-five years of age; (b) physicians with obvious physical disabilities which are disqualifying; (c) those rejected for all government service because of physical disability; (d) women physicians.

Some of this last group may be called upon to supplement their private practices by performing part-time service to meet community needs hitherto performed by men called to active duty. A large number now engaged in home duties, but

who have agreed to do work of any kind, anywhere, upon request of the Central Governing Board, will as the emergency arises be assigned to duty in the following places: (1) local and medical advisory boards; (2) institutions (medical schools and hospitals); (3) industrial plants; (4) health departments; (5) communities lacking medical service.

While under the selective service law individuals in the draft age are registered and inducted into the service as privates, the Volunteer Medical Service Corps enrolls and classifies individuals as prospective commissioned officers, and will assist in establishing the individual's status when he requests transfer from the enlisted forces to the commissioned branches of the service. Enrollment in this corps definitely registers the physician as a patriot and provides definite governmental recognition of his willingness to serve.

The Volunteer Medical Service Corps is exactly what its name indicates. It is a gentleman's agreement on the part of the civilian doctors of the United States who have not yet been honored by commissions in the Army or Navy, or enrolled in the Public Health Service, and a representative board of governors consisting of government officials associated with lay members of the profession, in which the civilian physician agrees to offer his services to the government if requested to do so by the Central Governing Board. This Central Governing Board consists of twenty-five men, the personnel being:

Surgeon General William C. Gorgas, U. S. A.
Surgeon General William C. Braisted, U. S. N.
Surgeon General Rupert Blue, U. S. P. H. S.
Provost Marshal General E. H. Crowder.

Dr. Franklin Martin, Chairman of Committee on Medicine and Sanitation, Council of National Defense.

Dr. Edward P. Davis, President, Volunteer Medical Service Corps.

Dr. John D. McLean, Vice-President.

Dr. Charles E. Sawyer, Secretary.

Admiral Cary T. Grayson, U. S. N.

Dr. F. F. Simpson.

Dr. Frank Billings.

Dr. H. D. Arnold.

Mr. W. Frank Persons—Red Cross.

Dr. Victor C. Vaughan.

Dr. William H. Welch.

Dr. Robert L. Dickinson, Chief of Staff's Office.

Colonel R. B. Miller, U. S. A., Chief of Personnel Division.

Surgeon R. C. Ramsdell, U. S. N., Chief of Personnel Division.

Colonel James S. Easby-Smith, Executive Officer.

Dr. Joseph Schereschewsky, Assistant Surgeon General (Personnel).

Dr. C. H. Mayo or Dr. W. J. Mayo.

Dr. William Duffield Robinson.

Dr. George David Stewart.

Dr. Duncan Eve, Sr.

Dr. Emma Wheat Gillmore.

To cooperate with the Central Governing Board in prosecuting all activities pertaining to the mobilization and enrollment of members of the Volunteer Medical Service Corps, an executive committee consisting of five or more members has been chosen in each state, and a representative designated for each county in every state. All men appointed to state executive committees and as county representatives are preferably over fifty-five years of age. The Central Governing Board receives and passes upon all appointments. The state executive committees receive facts from the county representatives and make recommendations to the Central Governing Board. The county representatives submit facts to the state committees, according to advice from the Central Governing Board or the state executive committees.

Following confirmation of the Central Governing Board by the Council of National Defense on August 5, President Wilson was immediately informed of the enlarged scope of the organization, and of the fact that the reorganized Volunteer Medical Service Corps is to include all legally qualified physicians holding the degree of Doctor of Medicine from legally chartered medical schools who are not already in a government service, whereas, the original organization included only physicians who because of overage, physical disability, and other reasons, were not eligible for service in the Medical Reserve Corps of the Army or Naval Reserve Force. The President replied:

My dear Dr. Martin:

I have received your letter of August 5, laying before me the matured plan for the reorganized Volunteer Medical Service Corps, of which you ask my approval. This work was undertaken by you under the authority of the Council of National Defense; it has had great success in enrolling members of the medical profession throughout the country into a volunteer corps available to supply the needs of the Army, Navy and Public Health Service.

In cooperation with the General Medical Board of the Council of National Defense, the strong governing board of the reorganized corps will be able to be of increasing service, and through it the finely trained medical profession of the United States is not only made ready for service in connection with the activities already mentioned, but the important work of the Provost Marshal General's Office and the Red Cross will be aided and the problems of the health of the civilian communities of the United States assured consideration.

I am very happy to give my approval to the plans which you have submitted, both because of the usefulness of the Volunteer Medical Service Corps and also because it gives me an opportunity to express to you, and through you to the medical profession, my deep appre-

ciation of the splendid service which the whole profession has rendered to the nation with great enthusiasm from the beginning of the present emergency.

The health of the Army and the Navy, the health of the country at large, is due to the cooperation which the public authorities have had from the medical profession; the spirit of sacrifice and service has been everywhere present and the record of the mobilization of the many forces of this great Republic will contain no case of readier response or better service than that which the physicians have rendered.

Cordially and faithfully yours,

WOODROW WILSON.

A special insignia consisting of a button has been designed for the members of the corps.

Every physician in the United States should enroll in the Volunteer Medical Service Corps because:

(a) The unsurpassed record of volunteer enrollment for actual service on the part of the medical profession must be maintained.

(b) The Army and Navy must not be ham-

pered for a moment for lack of doctors to care for the sick and wounded boys fighting our battles at the front.

(c) The great industries furnishing materials of war, employing thousands of patriotic workers, must have medical service.

(d) The home folks, the old and the young wearily waiting over here, must have doctors.

(e) Recording, classifying, and careful distribution and full utilization of our entire profession of medicine will, without hardship to anyone, enable us to instantly supply all demands, and our utmost resources will then be available to aid in establishing a permanent peace that will forever make this world a safe place in which women and children may live—a peace in the negotiation of which the enemies of civilization against which we are fighting shall have no voice.

A WAR PROGRAM OF VITAL IMPORTANCE

The Work of the Section of Medical Industry, War Industries Board, in Supplying Medical and Surgical Materials Necessary for Military and Civilian Requirements.

By LIEUT. COL. F. F. SIMPSON, M. C., N. A., CHIEF OF SECTION OF MEDICAL INDUSTRY, WAR INDUSTRIES BOARD.

I AM glad to have the opportunity of presenting to your readers a brief statement regarding the activities of the Section of Medical Industry, War Industries Board. The purposes are:

(a) To aid the War Industries Board to make available for war purposes a full supply of materials required for the military emergency.

(b) To insure an adequate supply of essential medical and surgical materials for industrial and other civilian requirements (for hospital, dispensary and home use).

(c) To assist in the conservation of medical and surgical materials on shortage lists.

(d) To cooperate with other departments in establishing appropriate preferential rating for civilian as well as military medical needs.

(e) To furnish other sections of the War Industries Boards, as well as other departments of Government, with information regarding the essential needs of civil and military medicine.

(f) To assist in every other way possible in securing essential materials for the care of civil and military population.

We feel that all who are interested in the welfare of the nation should realize that the first and imperative need of the hour is to render maximum service to the striking force of the nation by supplying what it requires; and second, with full consideration for efficiency and for humanity, to serve those who fall temporarily by the wayside in civilian life as well.

It is vital that every man, woman and child strive to the utmost to put the war program into maximum effect in a big unselfish way, even though it means inconvenience, the use of substitutes, etc. Each one must aid to the extent of actual sacrifice, with a full realization of the fact that, parallel to the utilization of existing facilities, there is a definite program to increase production of materials and facilities of which there is now some stringency.

Included in the constructive program are:—

(a) A proper rating of medical activities in relation to such fundamental needs as

Power (fuel, machinery, etc.).

Transportation of essential commodities.

Securing essential materials, such as steel, chemicals, etc.

(b) The rating of employees of hospitals and of medical industry, according to their relative importance in the war program.

In ascertaining the national needs of drugs, medicines, and medical and surgical supplies, it is our purpose to make inquiry regarding the probable needs of hospitals for the next six months, in order that the essential demands may be met as fully as possible. In effecting such a comprehensive program, it will not be possible to consider minor individual problems, but our desire is to assist in formulating principles and policies which will produce a supply sufficient to meet the essential needs of civil as well as military medicine.

WAR-TIME HOSPITALS PRESENT IDEAL CONDITIONS FOR INVESTIGATION

**Data Which Could Not Be Secured in Peace Time Are Now Possible Through Experimentation—Result Should Show Itself in Better Hospital Planning and Construction—
Suggestions for Making Most of Present Opportunity**

BY T. J. VAN DER BENT, ARCHITECT, MCKIM, MEAD & WHITE, NEW YORK CITY

THOSE who are well informed about planning and construction of permanent hospitals have realized on various occasions how great is the need of numerous data in respect to hospital features, equipment, and plan, each in reference to their being beneficial or harmful to patients or management. They also know that there is a great variety of opinion as to the layout, the details and plans, and a still greater variety in regard to many questions concerning equipment and mechanical installations. This difference of opinion leads to a large amount of happy-go-lucky hospital planning and construction. It is the natural outcome of a situation where lack of knowledge or lack of data to defend and sustain opinions has given opportunity to the domination of individual conjectures which are sometimes guesses and at other times "hunches," and which would have very little or no influence if judgment could be based on actual facts. To obtain facts or even to indicate probabilities, it is necessary to make a large number of experiments and observations, deriving conclusions only from the outcome or result in the great majority of cases. For various reasons these necessary experiments and observations cannot, unfortunately, be made in the permanent hospital of peace time. In the first place, these permanent hospitals are constructed and planned after a fairly well-decided pattern and according to a number of fixed rules, although it may be true that several of these fixed rules have been adopted without proof or foundation and have been simply absorbed as dogma. The variety of opinion among eminent men of the medical profession will be sufficient proof for this statement. The second difficulty met with is that the world at large would not concede the right of making such experiments to the hospital physicians. It would be considered criminal neglect if some patients, for the sake of comparison of results, were placed in less advantageous positions in respect to ward conditions, or in rooms where conditions were not considered the best. If it were desired, for instance, to obtain certain data in connection with the influence of mechanical ventilation, it would be necessary to place patients in wards of various sizes, with different exposures, different locations or distribution of windows, and different heating systems with or without mechanical ventilation. Observations would have to

be made with different room temperatures, and these observations should be considered during long periods in winter and summer. It is obvious that only few laymen would consider it proper that such experiments be made in the regular hospital, and it is even questionable whether the law would permit them.

The third and most serious difficulty in obtaining valuable data in the permanent hospital during peace times is the lack of identical cases and lack of variety in conditions.

If certain laws are to be derived from observations, if the reliability of certain data is to be established, chance must be eliminated, and this can be possible only when observations are recorded in a very large number of identical cases (patients suffering from the same disease or ailment to a fairly equal degree). Even in the largest general hospital the greatest number of identical cases treated at one and the same time is still very small, and in the regular course of treatment these cases would be subjected to the same exposures and influences. Consequently, there would not be opportunity to make comparisons for different situations.

If hospital construction and planning must continue after this war in the same manner as it has before, there will be little or no progress, and the time is near when there will be a decided turn in the wrong direction, if it has not already taken place. At present we continue to build without knowledge, on the strength of the private opinions of a few well-known men—opinions which have in many instances no semblance of support or no proof of being correct.

For the proper illustration of this situation let one example be considered here, viz., the question of mechanical ventilation. It is well known that for many years there has been a great variety of opinion as to the real value of mechanical ventilation. Many men of eminence have defended it as absolutely necessary; other men with equal knowledge and capabilities have strongly opposed it, and have stubbornly maintained that window ventilation (natural ventilation) is the only correct system. In the majority of modern hospitals, plants for the mechanical ventilating method have been installed at great cost, but in the greater number of instances these plants have been abandoned and are not in operation. This was brought

about through (1) the great operating cost and the attempt to save for other purposes by not running the plant; (2) adverse opinions of influential men connected with the institution; (3) neglect and ignorance of the engineering staff.

There are no definite proofs as yet which justify opinions for or against mechanical ventilation. The only method of obtaining proof is by careful, methodical, and continued experimentation. It is conceivable that from numerous records of experiments, proof can eventually be obtained that mechanical ventilation is of no value, or perhaps even worse—that it is harmful. But it is also possible that the reverse will be proved and that mechanical ventilation will show itself of decided advantage in the treatment of patients. This may not be conclusively established for all cases, but perhaps for a great many.

More through the accidental witnessing of extreme conditions than for any other reason, I would lean to the expectation of the last-mentioned result. If by various reliable experiments and the records derived therefrom it were proved that mechanical ventilation is of no value or harmful, I would cheerfully join the great number of men interested in hospital work, planning and construction, to write a fitting epitaph and to dismiss forever this subject of great discord. *This subject can not and will not be disposed of by dogma* which is in many instances preached by men who have not the slightest knowledge of the working of mechanical ventilation or of its possibilities, or of the scientific and unassailable laws upon which it has been conceived. Its actual value will be established by experiment only.

There are many more questions pertaining to planning, construction and equipment of hospitals to be settled which are as important or even more important. The example of mechanical ventilation was mentioned only on account of the regrettable and fruitless controversies in connection with this subject which have been sowing seeds of discord among professional men to the disadvantage of a great number of institutions, especially hospitals. It is of great value to obtain definite information about arrangement of beds in hospital wards, window spacings, general heating system, height of ceilings, width of wards, number and rows of beds, and many other items.

For a positive decision we can look only to the war hospital, and especially to the temporary and emergency hospital type. If the permanent hospital of ordinary times is an institution where experiments involving patients are difficult at all times, in most cases impossible or impractical, the war hospital presents a different situation. On account of emergency, a variety of conditions will

exist which can not be planned in a permanent hospital. These varying conditions will pertain to plan, construction, mechanical installation, classification and grouping of similarly affected patients, the placing together of a variety of cases, etc. The comparative small variety of disease and ailments in the military hospitals, and the naturally large number of similar, parallel or identical cases thus placed at the disposal of science, offers a field of comparison so large that to conceive an idea of such opportunity in ordinary times seems like expecting the impossible. No matter to what extent hospitals of the future may desire to proceed in the field of experimentation, the small number of identical cases will limit, if not defeat, the expected result. The great variety of conditions in the same group of buildings, which places similarly affected patients to numerous different exposures and influences, beneficial or harmful as each case may prove, will materially add to the advantage of observations in the war hospitals.

If consideration of the subject leads to the conclusion that advantage must be taken of the opportunity, the medical profession can, by appointing a small executive committee of good men, derive ways and means to attain the object in view. They will, of course, need first of all the approval and support of the War Department, and the Surgeon General. Means must be devised to have the observations recorded in the simplest manner, least interfering with the ordinary routine of the hospital. The correct form of the schedule or chart of observations will be a deciding factor in the minimizing of work and prevention of duplication.

Among the subjects of experiment and observation, I respectfully suggest that some consideration be given to the following, all of considerable importance in hospital planning and construction:

1. Effects of various temperatures in wards in connection with various percentages of humidity.
2. Effects of various degrees of window ventilation, not only as to cure and recovery, but also as to form and percentage of complications, especially pneumonia.
3. Different ceiling heights.
4. Placing of beds in reference to windows; distance from windows; single, double, three or four rows of beds.
5. Systems of heating.
6. System of ventilation—degree of mechanical ventilation or complete absence of same. Especially valuable are observations during very warm and very cold weather. The last are more so while complete or nearly complete closing of windows is apt to occur.

7. Air currents in wards of various sizes during different weather conditions, especially hot and severely cold weather.

8. Effect of single, double, and triple transoms.

9. Effect of drafts.

If, for later comparisons, careful records of the various conditions of rooms in which identical cases are treated are kept, as well as a correct record of the medical results, time of recovery, etc., it must lead without doubt to a definite decision as to which of the room conditions, which exposure or influence is the best, and which the most harmful. The later study of the records will definitely prove what before was hypothesis, or disprove faulty theories.

The enormous task already resting on the shoulders of doctors, nurses, and managing staff of the war hospital will exclude any but the simplest system of recording and observation. The suggestion which I here make of burdening these sincere and hard workers with additional labor and responsibility may meet with great opposition. Only after very careful consideration have I dared to broach this subject. Where, however, an enormous field of observation and comparison has been created by emergency or accident, not to be duplicated at a later time by the most autocratic powers nor vastest riches, shall we ignore this opportunity? Shall we let it be lost to the future, without taking some advantage of the rare occasion?

LITTLE JOURNEYS TO PLACES AND PEOPLE WORTH KNOWING

The Fifth Little Journey—To the George F. Geisinger Memorial Hospital, Danville, Pa.— An Ideal Endowed Hospital in the Pennsylvania Hills, Accomplishing Much for Its Community

BY MARGARET J. ROBINSON, R.N., FIELD EDITOR, THE MODERN HOSPITAL.

THE Geisinger Memorial is a beautiful hospital, inside of it and outside of it and for miles around it—beautiful, physically as well as mentally—beautifully built, and beautifully equipped and beautifully sanitary. After all, the first thing we know about a hospital is the hospital building itself, its equipment and sanitation, its offices and furnishings, its beds and its food. A hospital might have a most admirable and ethical board of trustees and staff organization, but if it didn't have good plumbing and good cooking and comfortable living quarters for its nurses it wouldn't be a very good hospital or a very successful one.

Think of it, you city dwellers, who pay forty or fifty dollars a week for a private room in a New York or Chicago hospital—a room on a shaft, perhaps, dingy with darkness and soot, and within sound of the traffic! Think of looking out of your windows at the Pennsylvania hills, brilliant in the sunlight or turning purple and black in the shadows, and your nearer vision seeing an immaculate and beautifully furnished room, and all for four dollars a day! The ward patient who pays only one dollar and a half a day gets the same wonderful hills to see and the same immaculate surroundings and intimate care.

The Geisinger Hospital has a wide porch and colonial pillared entrance, and spacious entrance hall. The walls are marble and highly polished below, unspotted and unbroken enameled plaster above. In the main hall hang two impressive portraits of the founders of the hospital, George F.

Geisinger and Abigail A. Geisinger, who gave the institution as a memorial to her husband. The hospital, when built three years ago, had a capacity of seventy-five beds and cost \$500,000. Mrs. Geisinger has endowed it with a trust fund of \$1,000,000, only the interest of which may be used for the maintenance of the institution. At the right as you go in are the offices. They have every equipment and a sufficient office force to do proper accounting and to make complete and systematic records. To the left of the hall are large and beautifully furnished reception rooms, all of which may be thrown into one room for meetings. Wiring is provided here, and direct current for projection apparatus.

At the end of the main corridor are large airy wards and glass-inclosed heated sun-rooms. There are eighteen private rooms in the building, several of them having private baths. A complete and satisfactory system of nurses' light signals is in use; also a ticker signal system, much after the fashion of the usual telegraphic instrument, which calls the visiting staff and officers to the telephone. All private rooms have telephones.

The hospital kitchens, nurses' and officers' dining rooms, and the refrigerating rooms are on the third floor. They are all beautifully clean and attractive and light and well ventilated. The superintendent's suite is on the third floor also.

The operating rooms are very complete. They are furnished throughout with everything that could be bought to insure good surgical methods



Fig. 1. The Geisinger Memorial Hospital, with a glimpse of the hills beyond.

and standards of aseptic surgery. The rooms are finished in white tile and Vermont marble. The seats of the Mayo Amphitheater are cushioned, an unusual concession to the comfort of visitors to the operating rooms.

I noticed in passing through the building that in each nurse's chart room, just in front of the desk, was an open wall space where, through the glass, the nurse sitting at the desk could see all parts of the adjacent ward.

The nurses' home is just east of the main building. It has attractively furnished reception rooms, writing room, and music room for the nurses. Through the windows at the side one can see the carefully rolled tennis courts. Most of the nurses have their own individual rooms. There is a beautiful suite for the superintendent of nurses and pretty rooms for the supervisors, a tea room for preparing light lunches, and good-looking china to serve them in. The bathrooms in the home are white-tiled, and have blue rugs. The halls are wide, have polished walls, and are carpeted with crimson velvet runner.

If all hospitals provided such quarters for domestic help as those given to them in the Geisinger Memorial Hospital, there would be less difficulty in obtaining help and keeping it. The rooms are so good that they stand out in sharp contrast with the usual dark and dingy corners in which many hospitals house their maids, and then wonder why it is so hard to keep good domestic servants.

The effect of these proper living conditions is noticeable throughout the building. Everything is clean and orderly. You feel that the men and maids employed take an interest in the place—that they are part of the organization. They were trim, neat, efficient-looking people, all of them that I saw. The domestic help have their own kitchen and serving room, where most of their food is prepared and served hot and palatable right to the tables of their dining room, which is next to the kitchen.

The hospital has a complete small isolation

unit near the ambulance entrance. A large Packard ambulance is used for the transportation of patients.

The staff organization of the hospital has been thoroughly standardized. Dr. Harold L. Foss, the superintendent, is also the surgeon-in-chief. He was formerly assistant at the Mayo Clinic at Rochester, Minn., and has organized the work at



Fig. 2. One of the reception rooms, with the office of the directress of nurses in the background.

the Geisinger Hospital on the same basis of staff organization and group diagnosis.

All the work of the hospital is done by a full-time salaried staff of specialists, acting under the direction of the superintendent and surgeon-in-chief. This organization makes it impossible for incompetent and inexperienced medical men to experiment in the hospital.

It is commonly stated that it would be impossible to keep a community hospital open unless the administration admitted to its privileges any man licensed to practice medicine in the state, and that such a staff organization as that just described, excluding local practitioners, would antagonize the community to the hospital. The answer is that the Geisinger Memorial Hospital,

which depends on a wide area of farming community for its patients, has outgrown its capacity in three years, and is planning to build again.

The finance committee of the hospital and the surgeon-in-chief meet each month at the hospital to adjust outstanding bills. To this meeting for-



Fig. 3. The main office, with the accurately adjusted master clock, the switchboard and signal and in-and-out check systems.

mer patients or those responsible for their accounts are invited. Notices like the following are sent out:

The bill enclosed is your account with the hospital. All bills are due on the first of the month after being presented and are to be paid at the office in the hospital.

The House Committee meets at the Hospital the second Friday of each month (or oftener if required) at 7.30 in the evening for the purpose of investigating complaints and adjusting bills of patients, should such action be found necessary.

The next meeting will be held Friday evening,
—191— at 7:30 o'clock.

Please bring your bill.

I attended one of these meetings in the office of the surgeon-in-chief. Several men appeared, most



Fig. 4. One of the reception rooms in the nurses' home—a charming interior, with most artistic furnishings.

of them unskilled laborers with families to support—not objects of charity but men who would be thrown into debt by any accident or illness that would bring financial obligation beyond the cost of the barest necessities of life. Each case had been investigated previously. Each man in turn was courteously greeted and asked to sit down.

The first bill was for sixty-three dollars, and the following dialogue took place:

"Are you working, John?"

"Yes, sir."

"Where are you working, and how much do you get?"

"Eighteen dollars a week."

"How many children have you?"

"Three, sir."

"Have you laid anything by, or are you in debt?"

"You can't help be in debt these days, the way everything costs."

"We'll not add to your burden man; the bill is canceled. We'll send you a receipt."

"Thank you, sir." The voice was husky.
"Good-night."

The second case was that of a butcher's clerk, getting ten dollars a week. This man has two children, the oldest eight years old; has no coal in yet. Bill of twenty-five dollars canceled.



Fig. 5. A sunlit mountain-cooled sunparlor.

In the third case there was continued illness in the family, and the wage-earner did not receive sufficient to provide necessities. Bill of fifty dollars reduced by finance committee to twenty and receipt in full sent.

I have tried to say something technical about this strangely human business meeting, but all I can think of is this: God bless the woman who made this thing possible, and the men who have the understanding to carry out her purpose.

FROM OUR FIELD EDITORS' NOTEBOOKS

A Small Hospital With Ideal Natural Surroundings—A Nurses' Training School Which is an Integral Part of a University—A Hospital Mascot

Reid Memorial Hospital, Richmond, Ind.

The Reid Memorial Hospital owns fifty-five acres of land, lawn, and vegetable gardens, woods and rocky paths and ravines. The nurses' home connects with the main hospital building by a covered passageway opening out of the first-floor sun parlor. The nurses' home is an old residence, one with big roomy bedrooms and fine old woodwork and staircases. The trees are so thick around the house and so close to the windows of the bedrooms that the bird chorus wakes the nurses up early in the morning. The sleeping porch is over a deep wooded ravine. At this time of year the nurses are enjoying summer resort privileges.

The hospital boasts of a unique entrance hall decoration—a wonderful vase about six feet high, the cost of which would equip a much-needed pathological laboratory.

The woman's auxiliary of the hospital is a very live and active one. The ladies furnish linens and supplies whenever needed. Their meetings are well attended and are working meetings, where linens in plentiful amount are made for hospital use.

The nursing education given at this hospital compares more than favorably with that given by much larger and supposedly better hospitals. A thorough curriculum is carried out and demonstration classes are followed. The nurses leaving this training

for support. Its rates for the care of patients are surprisingly low at this time when unusual conditions have made per capita cost so high. In fact, in spite of the excellent business management of the superintendent, Miss Clara Pound, these low rates leave no margin for the necessary growth of the hospital.

The Reid Memorial Hospital lies in most picturesque



Fig. 2. A view of Reid Memorial Hospital showing some of the beautiful surroundings.

and beautiful setting. Its nursing education is of the best. It has human atmosphere and kindly care to the sick and a splendid force of women in charge of it. It is unfortunate that this hospital has not more modern scientific equipment for diagnosis.

The American Hospital, Chicago

The American Hospital started its career some years ago in a small and poorly equipped building. Even then it began to prove itself one of the Good Samaritans, and gave free bed care to many who could not afford to pay for the care they needed.

Through several years of struggle and evolution toward better things, it has kept its courage and its charity, and now can boast of its new well-finished building, having all means to make scientific diagnosis and giving the best nursing care to its patients.

Dr. Max Thorek, the chief surgeon, who has given some of the best years of his life to the building of the hospital, plans to make the hospital standard in every way, and to give the best of nursing education to the young women who come there for a nurse's training.

A more complete description of the work of the American Hospital will be given in a later number.

Hackley Hospital, Muskegon, Mich.

school have the best education that the supervisors of this hospital can give them with the means at hand.

The hospital has very little endowment or public funds

The name Hackley, in Muskegon, is synonymous with philanthropy. Charles H. Hackley, one of the pioneer lumbermen of the state of Michigan, made millions in the



Fig. 1. Entrance hall at Reid Memorial Hospital, with its wonderful and costly vase.

timber of the early days, and then had enough love and faith for his own city to finance its industries after the lumber boom died down, and to give it four and a half millions for the public welfare, in a library and art gallery, parks and educational funds, a manual training school and an endowed hospital.

This hospital some few years ago was named as the ideal small endowed hospital and Johns Hopkins as the ideal large endowed institution of the country.

The hospital was opened for patients, November 17, 1904. It is built in the midst of four city blocks of ground and its lawns and gardens have been for years the

do it, Joe should stay where he is and be made a doctor. He has had three and a half years' start on his education, and his life and his future could not be in better hands.

Robert W. Long Hospital, Indianapolis

The Robert W. Long Hospital is a part of the Indiana University School of Medicine, and is under the control of the educational committee of the school. The training school for nurses is one of the few in this country which is an integral part of a university.

The training-school course is for three years. Students who have completed three years' work in an acceptable college are given eight months' credit towards a diploma of the school, and a combination course is offered whereby students are given credits toward a degree for the training-school course taken. The nurses in the Robert W. Long Hospital work on the eight-hour schedule—eight hours on week days and six hours on Sunday.

The hospital is a splendid building of solid steel construction and dignified architecture, fitting in well with the university atmosphere. The system of units of service is well planned. Each department centers about a large



Fig. 3. The American Hospital, Chicago, with the research laboratory at one side.

pride of that part of the state. It was originally to be a 50-bed hospital, but with administration facilities to account for its ultimate growth. At present it has a capacity for 100 patients.

During the last year a new and adequate nurses' home has been built. A department for pediatrics is being constructed, and new and complete radiographic and pathological laboratories have recently been installed. A new obstetrical pavilion is also planned, as this branch of the hospital's work has so far outgrown its capacity to handle it.

The day that I visited Hackley Hospital, Miss Grace McElderry, the superintendent, sent for the hospital mascot, Joe. Joe is a part of the hospital. He was born there, and his mother died there two weeks later of tuberculosis. He is three and a half years old now. He was born a poor scrawny wisp of a baby that didn't seem to have any chance at all, but by the combined efforts of most of the doctors of the staff, the hospital officers and the nurses, Joe now is as sturdy a little chap as you would like to see, and he belongs to everybody. Everybody concerned is also determined that he shall not go back to a foreign tenement house environment if they can help it.

Joe has his place at the table in the officers' dining room. He calls the superintendent "Dama," the assistant superintendent, Miss Gray, he calls his "Dray," and when the women visitors or the officers of the hospital go out of the door or into the elevator he opens the door for them and says "Ladies first, please."

I quite agreed with them that if there was a way to



Fig. 4. Hackley Hospital, Muskegon, Mich., an ideal small endowed hospital.

hall. All wards and service rooms open on this center of administration. Each unit has its own convalescent dining room. All the rooms are light and well ventilated.

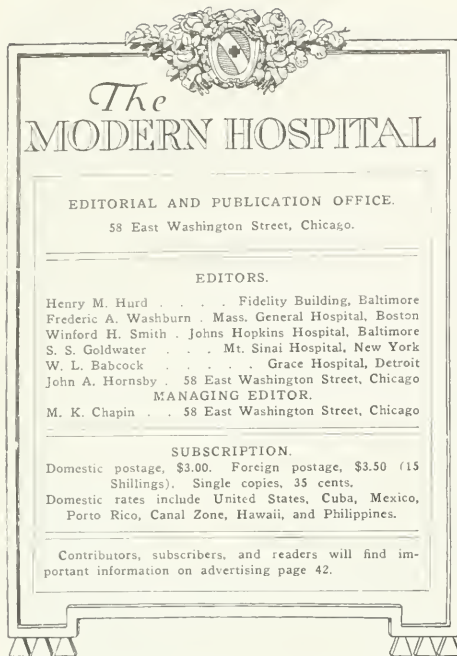
A complete dispensary and social service department is maintained in connection with the university. The students of sociology cooperate with the out-patient service and the follow-up work.

The Robert W. Long Hospital offers to students in the University School of Medicine exceptional opportunity for clinical material and study of social problems and to nurses, exceptional opportunities for advanced education.

Elm City Hospital, New Haven, Conn.

Elm City Hospital in New Haven, Conn., is a private hospital which gives high-grade service to the patients of a group of surgeons and physicians well known in that city, most of whom are on the staffs of the larger public hospitals. It has a sixty-bed capacity and employs graduate nurses only.

The hospital cares for a large number of surgical cases, but is especially equipped for the treatment advised by the specialists in internal medicine. This department is in charge of Dr. Robert E. Peck, an internist and neurologist of New Haven, and has facilities for hydrotherapeutic and electropneumatic treatment and various forms of massage and light therapy. The dietetic department pays special attention to diet in disease.



The American Hospital Association Meeting

Owing to unavoidable conditions of publication, this portion of THE MODERN HOSPITAL will have been printed before the Atlantic City meeting takes place. An account of the meeting with comment on the events will be found on page 310 and following pages.

The Fourth Liberty Loan

At the present writing, the American nation has great cause to join with our allies in thankfulness for the triumphs of our armies on the western front. We have indeed justification for an optimistic feeling that our war-weary world is reaching the goal where lies the full contentment of a lasting peace—a peace for ourselves and all posterity. Yet optimism alone will not win.

By the time this issue of THE MODERN HOSPITAL is in the hands of its readers, the country will have once more been asked to lend its aid yet again, and give its patriotic support in successfully raising the sum of six billion dollars, for which amount the Fourth Liberty Loan will call. No appeal for past liberty loans has gone by unheeded, and with victory clearer and nearer in sight than at any other period of the war, it behooves all, high and low, rich and poor, to dedicate the full strength of their resources to

the cause for which this loan is called. The government is not asking the loan of any one's money without full remuneration for its use; it is merely asking a loan, guaranteeing to the lender a safe and sure return of his or her money, together with a full and fair interest. The moneyed man has no preference over the person with meager means; all share alike for each dollar that is invested. For the person who has a small sum to invest, it is the means of a secure investment with a certain return of interest; for the man who has large sums at his disposal, uncertain in these days of fluctuation in stock values, and who is desirous of obtaining the use of his money whenever an urgent need demands, no better solution to such a problem presents itself than the investment in Liberty bonds. No sane person will turn down a security backed by the greatest government of all times.

The hospitals have already done, and are still doing, their part in response to the call made on their resources, both from a standpoint of humanity and financial aid. This call will also come to them, giving them another chance to make shine with a still brighter luster the glory that is already theirs. THE MODERN HOSPITAL bespeaks for all hospitals and allied institutions, from the highest official to the lowliest, a ready and eager answer to this call. Benefactors will be able to satisfy at once both patriotic and charitable impulses by making their gifts to hospitals in the form of Liberty bonds.

A Message From Belgium

Among the distinguished foreigners whom this country had the honor of entertaining during the last meeting of the American Medical Association was a member of the Mission on Industrial Management, Belgian Ministry of Reconstruction, Captain Dr. René Sand.

One of the editors of this journal asked Captain Sand, during his visit here: "How may America best pay her share of the debt of gratitude which the whole civilized world owes to that heroic and undaunted little country? What can we best do to help Belgium after the war?" Captain Sand very kindly promised to prepare an answer to this question, for presentation through the columns of THE MODERN HOSPITAL, and we have the privilege of publishing that answer among our leading articles this month.

The first few months of peace, Captain Sand says, will be decisive of the fate of Belgium—and perhaps, by the way, the same might be said of other nations that have not had to endure Belgium's martyrdom. That stricken country will need material help, personal help, and advice.

Almost all the social problems which are constantly present everywhere—infant mortality, bad housing, occupational hazards, tuberculosis, alcohol, venereal diseases—will present themselves for solution in their most acute forms. Yet, as Captain Sand very truly suggests, in the heart of this desolation lies an almost unparalleled opportunity, for seldom or never has a nation, having seen its ancient civilization shattered to bits by a vandal invader, found the will and the way to remold that civilization nearer to the heart's desire. To assist the indomitable little Belgian nation in establishing itself on a higher level than ever before should be for this country a high privilege.

A permanent American foundation in Belgium, to foster research, to offer information on reconstruction problems, and to maintain an educational campaign for raising the standards of life in Belgium, would, in Captain Sand's opinion, be the ideal means of serving his country and of strengthening the bonds of friendship between Belgium and America. We forbear to quote here the graceful compliments which he pays to the genius and generosity of this country; but we heartily commend his suggestions to the consideration of our public-spirited fellow-countrymen.

The Volunteer Medical Service Corps

On another page we publish a statement by Dr. Franklin Martin on the subject of the reorganized Volunteer Medical Service Corps. The plan, which has President Wilson's approval, makes eligible to membership in the corps all legally qualified physicians in the United States (including women, but excepting physicians already in government service), without regard to age or physical disability. The blank to be filled out will supply exceedingly complete data in regard to the qualifications of each applicant; in fact, the value of such a collection of statistics in regard to the medical profession of the country can scarcely be overestimated. Members will be entitled to wear insignia indicating their willingness to serve the government, which they will have manifested by subscribing to the following pledge: "I pledge myself to abide by the rules and regulations of the corps; to apply for a commission in the Medical Reserve Corps of the Army, the Naval Reserve Force, or for appointment in the Public Health Service when called upon to do so by the Central Governing Board; and to comply with any request for service made by the Central Governing Board."

The organization gives control to a central governing board of twenty-five members, appointed,

with the approval of the President of the United States, by the Council of National Defense, and the affairs of the corps will be conducted from general headquarters at Washington. Forty-nine state governing boards and state executive committees are provided for. The members of the former consist of the members of the state committees of the Medical Section of the Council of National Defense, while the latter are to be nominated by the state boards from among their own members. County "representatives" for each county of fifty thousand population or under (with additional "representatives," in larger counties, for each additional fifty thousand population or fraction thereof) are to be nominated by the state executive committee. The duties of the state governing boards, however, are merely "to receive facts from county representatives and make representations to Central Governing Board," while those of county "representatives" are "to submit facts to State committees according to advice from Central Governing Board or State Executive committees." The purpose and scope are defined as follows: "Volunteer Medical Service Corps organization: (1) provides means for obtaining quickly volunteer men and women for any service required; (2) furnishes recommendations and necessary credentials to assure the best of medical service, both military and civil; (3) determines beyond question the attitude of the individual toward the war." The object of the corps is stated to be "(1) placing on record all medical men and women in the United States; (2) aiding Army, Navy and Public Health Service in supplying war medical needs; (3) providing the best civilian medical service possible; (4) giving recognition to all who record themselves in Army, Navy, Public Health activities or civilian service."

The scheme is a masterly one, and the service to be performed by such an organization is indispensable to a true war conservation program. In view of the acute need of using the medical resources of the country as wisely and economically as possible, it is clearly of the first importance to find out exactly what those resources are, and to secure the cooperation of physicians in applying their services where they will do the most good. Just as clearly is it the patriotic duty of all physicians to place themselves on record and at the disposal of the national government.

Yet those who study the form of organization of the Volunteer Medical Service Corps may not be able to refrain from wishing that so fine and sweeping a vision had included a little deeper view into the future. That the medical profession will relapse at the end of the war into the

unregulated individualism of ante-bellum days is scarcely conceivable. In the better-organized world which, we must believe, is going to emerge from the floods of the present disaster, physicians, like other men and women, will have to sacrifice something of individual caprice and privilege for the benefits of a more solid and stable order of things. What a splendid foundation a Volunteer Medical Service Corps would have made for the future organization of the medical profession! Indeed, although the organization is, of course, created to meet war conditions, we find no provision for disbanding at the close of the war, nor is it imaginable, if the plan succeeds, that what has been accomplished at such cost will be thrown away at the coming of peace. The very records of the organization will be of immense value—and a lever of tremendous power in the hands of those who have learned to use them. That the Volunteer Medical Service Corps will dissolve and, like the baseless fabric of a vision, “leave not a rack behind,” is scarcely conceivable. It is hoped that in due time a way will be provided for a transition from the present purely autocratic military form of control by officers appointed from outside of the organization, to the representative form of government which will, of course, be demanded when war is over. The pledge of the candidate “to comply with any request for service made by the Central Governing Board,” of course, lodges in the hands of that board an immense power. Only the exigencies of war could justify such a pledge, particularly when made to a board which is not responsible to the governed body.

We believe that this power will be exercised wisely and well by the present Central Governing Board. We also think that medical men can not think too soon or too seriously about what is to be the final issue. Meanwhile, as we have said, it is the duty of all medical men and women to place themselves at the nation's service, and all patriotically guided hospitals will see that the matter is placed with proper emphasis before the members of their respective medical staffs.

An Appeal for Nurses From the Red Cross Department of Nursing

From the Department of Nursing of the American Red Cross at Washington comes the following appeal to the physicians of America:

Surgeon General Gorgas has called for a thousand graduate nurses a week—eight thousand by October 1. Twenty-five thousand graduate nurses must be in war service by January 1—in the Army Nurse Corps, in the Navy Nurse Corps, in the U. S. Public Health Service, in Red Cross war nursing. This involves withdrawal of many

nurses from civilian practice and necessitates strict economy in the use of all who remain in the communities.

You can help get these nurses for our sick and wounded men by:—Bringing this need to the attention of nurses; relieving nurses where possible wholly or in part from office duty; seeing to it that nurses are employed only in cases requiring skilled attendance; insisting that nurses be released as soon as need for their professional service is ended; seeing that your patients use hospitals instead of monopolizing the entire time of a single nurse; encouraging people to employ public health nurses; instructing women in the care of the sick; inducing high school and college graduates to enter the Army School of Nursing or some other recognized training school for nurses.

Encouraging nurses to go to the front involves real personal sacrifice and added work on the part of the physicians whose duty it is to maintain the health of our civilian second line of defense—but the men who are fighting for their country in France need the nurses.

A Well-Directed Offensive Against Political Jobbery in State Institutions

The executive committee of the New Jersey State Hospital recently adopted a motion recommending to the State Board of Charities and Corrections of the State of New Jersey the adoption of a rule that in the future only medical men may be employed as chief executive officers of state hospitals for the insane, special institutions for the feeble-minded and for the state epileptic village. In some of these institutions responsibility for management has been divided between a lay superintendent and a medical director, causing more or less friction, according to the committee, and this dual control is characterized in the resolution as “illegal and just as unwise and impossible in the management of institutions as it is in business enterprises.” It is also urged that in choosing chief executive officers, medical directors, first assistants, and other physicians holding positions of similar responsibility, the local boards of managers of the state institutions be required to confine their choice to those who have had medical and psychiatric training and experience sufficient to qualify them as leaders of their profession, who are fully abreast of the times, who possess a first-hand acquaintance with all the latest methods, procedure, and discoveries in the field of medicine, neurology, and psychiatry, and who have, in addition, administrative qualifications of a high order.

It has long been one of the crying scandals of the hospital field that it was possible for state and city administrations to make appointments to the supervising positions in state institutions without regard to the qualifications of the applicant to fill these positions of responsibility in the care of the mentally and physically ill.

Many of the so-called wardens or superintendents of state institutions have brought with them

to their administrations only political power and ability, which has been used often to pay political debts or to line their own pockets, and officers of a high grade of skill and conscience have frequently been handicapped and humiliated by political appointees who have no conception of the professional side of hospital management.

If the State Board of Charities and Corrections of the State of New Jersey make a ruling which in future will form some control of this situation they will have made creditable progress against the political control of hospitals, and will have established a precedent which will be an inspiration to other politics-ridden states to follow.

The Increased Need for Care of the Public Health

We have in previous issues emphasized the need for giving not less, but more, attention to the civil hospitals during war than during peace. This need is illustrated by the following extract from a letter written by an officer of a small hospital in an Atlantic seaboard state:

"Usually during the summer, people around here are too busy to come to the hospital and are up and down at home with a doctor in attendance. This year, many of the doctors being in the service, it is necessary to come to a hospital for treatment, and this institution has been busier for the past seven months than at any time before."

In one county in another southern Atlantic state, before the war there were six doctors, or one for every 673 persons. Two of these physicians have already been commissioned, leaving only four doctors for the whole county of 422 square miles; and of these four one has written to the state board of health stating that he is frequently laid up with arthritis during the winter and does not know how much he will be able to do during the coming winter. From an Allegheny mountain county a physician writes to the medical authorities of his state that he is now the only physician in a wide area and that children are dying for want of medical aid. In still another community in the same state there were three physicians before the war, one for each thirteen hundred population, a much larger population than one physician can adequately care for in peace times. One of these three physicians has been commissioned, leaving almost two thousand persons for each physician to handle. (The foregoing statements are drawn from a publication of the School of Social Work and Public Health, Richmond, Va., of which Dr. H. H. Hibbs, Jr., is director.)

An overburdened physician in one of our large cities has said that the shortage of medical and

nursing care for the civilian population would adjust itself if physicians and nurses would devote themselves to patients who really need attention, leaving the hypochondriacs and the people with trifling ills to find out that they can, if they must, get along just as well without the sheer luxury of medical and nursing care. No doubt, some such taste of privation may be good for at least a certain section of our overpampered urban population; but we must not forget that there are other sections, especially in the rural districts, to which sickness is not a luxury, but a grim and deadly enemy. We must not forget the urgent need of everything which may help the few doctors who are left to care for the needs of this deserving class. Public health nurses and community hospitals are not a luxury, but a necessity, in these districts.

What Are Hospitals Doing to Conserve Food?

How much is your hospital doing in the way of conservation of food materials? Can it be that some of our institutions are taking unfair advantage of the leniency to hospitals? While it is true that consideration for the sick is perfectly justifiable, yet it is a little difficult for the layman to understand why nurses, doctors, and employees of a hospital should be given the same consideration as patients.

Why, for instance, should hospitals be allowed to use sugar and wheat bread in unlimited amounts when every one in the country is asked to limit the consumption? When private individuals and public eating places are abiding strictly by the regulations of the Food Administration, it is a little disturbing to go into hospital after hospital and find no restriction whatever on the use of sugar by any employee or resident and to find bread being wasted in large quantities, nurse after nurse taking three or four slices of bread from the plate, at least two of which later come out of the dining room with the soiled dishes and are thrown in the garbage. To have a large pan of partly eaten rolls, made without thought of substitute flour, come into the kitchen every morning from a staff dining room where twenty or twenty-five people are served, seems little short of criminal.

The nurses and doctors in the operating room of a certain hospital were having eggnogs made of cream and certified milk during the whole summer, when fruit juices, iced tea sweetened with maple sugar, or plain milk with wafers or sandwiche might very well have been substituted. The country has been asked to use beef sparingly; yet we know at least one hospital which has served steaks to every one, including wards and

employees, two and three times each week. These are a few things actually occurring; many others might be added.

The foregoing is not intended to discredit the excellent work in conservation done in many of our institutions. It is merely an appeal for fair play. Let it not be said that there are "slacker" hospitals, which by their self-indulgence and carelessness offset the best efforts of all the rest. With so many of our nurses and doctors giving everything in the service of our country should we not be willing to give a little thought to the same service in all our hospitals?

Another Staff Member Called for War Service

THE MODERN HOSPITAL has been highly honored in the number of its staff members who have been called to positions of responsibility created by war conditions. To share, by giving up our best, in the sacrifice that all are making, becomes, under such circumstances, a privilege as well as a duty. The most recent call for this philosophy comes in connection with a request from the American Red Cross in France that we lend the services of our field editor, Miss Margaret J. Robinson, as a technical writer on war hospitals and hospital work in France. Our readers have already had an opportunity to become well acquainted with Miss Robinson's work, and will join with us in wishing her, in this new literary field, all the success which her exceptional qualifications undoubtedly assure her.

Who Are the Blind?

In the department devoted to Industrial Rehabilitation of Disabled Soldiers and Sailors, Mrs. Sidney McCallin describes a magnificent work—a work without precedent—which is being done in England for the blind soldiers and sailors of Great Britain. Affectionate care and far-sighted intelligence combine to restore to the blind man his birthright of happiness and usefulness. Indeed, according to Mrs. McCallin, the intensive training at St. Dunstan's often more than compensates for the loss of sight. The men are not resigned, but happy, and in many cases rendered more efficient and valuable members of society than they were before.

A magnificent work indeed! Let us rejoice that a way has been found to pay a portion of the debt that society owes to those who have hazarded in its defense life and all that makes it sweet. Let us in this country learn all we can of the methods of this beneficent foundation, and apply them according to the need which will soon arise.

Yet one thought rises unbidden. What kind of civilization is it that makes it necessary for men to lose a sense before they can have the training that makes possible the attainment of greatest happiness and usefulness? To lavish every care on those who have broken and spent themselves in our service is justice, not charity; but what a commentary on our civilization is the fact that a man must literally give his eyes to gain his fullest development! How many wasted lives might be saved if we only realized that the great work of a civilized community is not making steel or mining coal or raising wheat, but making human beings happy and useful! Are we the real blind?

THE CIVIL HOSPITALS AND THE ARMY NURSING SCHOOL

Hospital Conference of the City of New York Protests Against Transfer of Senior Nurses to Army School

A letter from the office of the Surgeon General of the United States Army suggesting that certain hospitals transfer to the Army School of Nursing considerable numbers of senior and possibly intermediate pupil nurses has come to the notice of the Hospital Conference of the City of New York, representing more than forty hospitals which conduct training schools for nurses. It is believed that this letter was sent out through a misunderstanding, for on June 1 the Secretary of War, in correspondence with representatives of the American Hospital Association, declared that "under no circumstances is the army to call out the second- and third-year pupils; that would be a body blow to the hospitals, and it is unnecessary."

The purpose of the Surgeon General's appeal appears to be to meet the shortage of nurses in the army.

A careful analysis of the situation shows that the shortage of nurses in the army can not be fully met in the manner proposed, and can not be even partially met without seriously impairing the efficiency of the civil hospitals, not only in the care of their own sick, but in the training of nurses and hospital assistants for army purposes.

The hospitals of the City of New York greatly desire to render adequate aid to the army in this emergency, and have been informed that at a recent conference in Washington at which the Surgeon General's office was amply and presumably authoritatively represented, it was decided to develop a program for the participation of the civil hospitals in the training of pupil nurses and hospital assistants (nurses' aids) in affiliation with the Army Nursing School. The Hospital Conference is of the opinion that such a program should be prepared immediately by the Surgeon General's office in conjunction with the representatives of the American Hospital Association, and should then be presented to the hospitals of the entire country as a substitute for the makeshift proposal above referred to.

On the completion and promulgation of an adequate and dependable program, calculated to meet the army's nursing needs throughout the war, the Hospital Conference will devote its best energies to the execution of such a program, in loyal devotion to the government and in hearty cooperation with the medical department of the army.—Resolution adopted by the Hospital Conference of the City of New York August 26, 1918.

OBSTETRICS AND THE HOSPITAL*

General Indifference to Obstetrics—Need for Skilled Care and Hospital Facilities—Delivery Room as Important as the Operating Room

By CHARLES E. PADDOCK, M. D., Obstetrician,
St. Luke's Hospital, Chicago, Ill.

The department of obstetrics has not developed as other branches of medicine have. The reason is made plain if we study past conditions, which allowed medical students to graduate without ever having seen an obstetrical case, and permitted ignorant women to act as midwives.

The law demands that a man or a woman must have had three or four years of medical training and have received a diploma before he is allowed even to write a prescription for a dose of medicine; but to the midwife who has the most limited preparation and scarcely any education, the right is given to attend a woman in childbirth. Fortunately this state of affairs gradually is being changed, but not as yet changed enough for us to obtain much benefit. It is because there is such indifference to obstetrics that the laity are slow to accept new methods, and physicians are content to go along doing things in the same old way.

Somehow we must be roused! For in the past twenty-five years the mortality and the morbidity due to childbirth have not much lessened and will not improve until the department of obstetrics is placed upon a higher plane of observance. A woman in labor may now be attended by anyone, and during the delivery any place is good enough for the patient. Every obstetrical case is a surgical case and the sooner that the fact is accepted by all concerned, the better it will be for the mother and the babe.

To operate upon a woman who has a small tumor of the breast, a skilled physician surrounded by all the modern conveniences of the hospital is demanded, while the woman in labor is left at her home, where no pretense at cleanliness is made. Perhaps she occupies a room which recently has contained a contagious or septic patient and is attended by the family physician, who must of necessity neglect her because he has other patients demanding his attention. Also the obstetrical case is nursed by friends who are willing and loving but who are entirely ignorant of the first principles of surgical cleanliness. Is it any wonder, then, that our mortality and morbidity are so great?

From the fundus of the uterus, down through the genital tract, to and including the vulva, there is a wound surface, torn, bruised, and bleeding. It is necessary that this wound surface be protected from outside contamination with pathogenic organisms. It is necessary that tears be properly repaired, that the integrity of the parts be maintained and that infection be prevented.

With these facts before us, why should the patient with the small tumor be sent to a hospital and the woman whose life is being jeopardized in childbirth be left at home under unhygienic surroundings? There are reasons that make such a practice possible. But I think you will find the most telling reason to be sentiment—for instance, either the father or mother or a dear relative was born in a certain home and the expected child must, likewise, be born there. Besides, there is a traditional belief that "only paupers are born in a hospital." Added to sentiment and tradition, fear is another reason frequently given for not going to the hospital to be con-

finied. Only recently I heard a fairly well educated woman say "they" would strap her to a table with her feet in the air. Another one knew that "they" would change her child and give her the baby belonging to someone else.

Then there is the fear of the physician that his patient may not get the proper attention because he is not a member of the staff of that particular hospital. In the latter case there may be some excuse for his concern. Occasionally I have been obliged to attend a case in a strange hospital, and I knew that my patient did not get the attention she deserved because I was handicapped by not knowing the nurses and the interns. With or without foundation, there is no doubt that such impressions often deter a physician from taking a case in labor to a hospital. Sometimes a physician feels that his patient is lost to him for future confinements if he sends her to a hospital. For often the nurse tells the patient that she has never heard of her doctor and that "Dr. So-and-so" of "our hospital" is a much better man.

Then, financial reasons are frequently given for not placing an obstetrical case in a hospital, and unless one occupies a ward bed there must of necessity be more expense attached to the case than at home. But after all, want of knowledge on the part of the patient, that the hospital is the better place in which to give birth to her baby, is one of the main reasons for so many deliveries at home. More and more, however, women are seeking the hospital for their confinements, and those of us who are limiting our practice to obstetrics are seldom told by the patient that she wishes to remain at home, but usually are asked immediately what hospital we shall suggest.

Twenty years ago, one would rarely hear of a woman's going voluntarily to the hospital to be delivered, but now both the rich and the poor are making reservations there weeks before the expected time. This fact shows that the movement is growing; that people are becoming more enlightened as to the benefits of such a procedure.

The physician who is doing careless obstetrics at the home will do better work at the hospital because he knows he is being watched by bright, active, young interns and nurses. Yet not all the poor obstetrical work is done at the home, because occasionally a physician whose work is far from what it should be will become associated with a hospital. This man, however, will not stay long. He is soon found out.

One in a position to observe cannot help but be shocked when he sees the inferior surgery that is being done at the homes. Daily women in labor are brought to the hospital in a mutilated condition, the babies still unborn, but dead, killed by the brutal use of instruments. These women and these babies are victims of poor obstetrics; and we see only a very small fraction of such victims.

The family is frequently a disturbing element at a confinement because its mental attitude toward the physician, who so frequently needs encouragement, is anything but helpful. The demands by the family that something be done to hasten the delivery often causes the physician to interfere before he should, which results in injuries to both mother and babe. But at a hospital there is not the same opportunity for the husband to interfere, for there the doctor, with the assistance of his nurses and interns, who share his responsibilities, is able to leave the room when he considers it necessary for the good of the patient.

Because hospital facilities are in themselves so valuable, it is unfortunate that these facilities are within the reach of the few. And yet, as year by year, every little village is building its hospital, it will not be long before these facilities will be within the reach of all. And as capable

*Paper read at the Third Convention of the Catholic Hospital Association, June 18, 19, 20, 1918.

men and women are connected with these institutions, it is no longer the rule for people to seek the larger cities for experienced physicians and hospital advantages.

Those of us in the larger cities, who think we excel in such blessings, might with profit study the work in some of the rural hospitals. Obstetrics cannot be done in the home, any more than abdominal surgery can be done there. Neither, however, can obstetrics be done in a hospital without a well-organized department. One is as impossible as the other. The patient had better remain at home than to be cared for in a general hospital with no special department of obstetrics.

So every hospital should have its maternity department, which consists of surgeons, interns, and nurses qualified for the work. At the head of the department should be a well-trained graduate nurse in charge of all, one who has had special training in a maternity hospital. The hospital will protest that it cannot afford such luxuries. But the time is coming when it must!

Aside from reasons of sanitation and safe delivery for the mother, there is another reason why the hospital should be selected as a proper place for confinement, and that is the special interest of the infant. There frequently comes a time in the delivery of a woman when it becomes necessary for the physician to act promptly to save the life of the babe. I am sure that almost any physician will say of some case or other, "Had I had my patient in a hospital, I should not have lost the baby."

It has been a great source of satisfaction to me in the past few years to know that I have saved the lives of many babies, because I had my patients in the hospital. I know from experience that many of them would have been sacrificed at the home. The physician watching at the bedside of the woman in labor, frequently testing the heart-beats of the unborn babe through the mother's abdomen, occasionally notices that the life of the infant is being jeopardized. He knows that there are only a few minutes left to save the child. If his patient be at her home, assistants must be sent for, arrangements for the operation attended to and much time is lost. The baby is sacrificed! In a hospital conditions are different. Assistants are ready, the patient is quickly delivered, and the baby saved.

Any case at any moment may become an emergency case. With the most favorable prognosis, something may suddenly develop that calls for the delivery. This is not a dream but a fact! So serious a fact that in conclusion I beg of the hospitals that they give as much attention to the delivery room as to the operating room, and that obstetrics be taken as seriously as a surgical operation and treated in the same manner, and that the obstetrical department be given all the skill, all the surgical cleanliness of the surgical case. That it help us by its hearty cooperation is my earnest appeal to the organization that I have the pleasure of addressing this morning.

A Patriotic Economy

When there are so many occasions for sacrifice, an appeal to patriotism which is also an appeal to self-interest should certainly find no slackers. Such an appeal to the hospitals of the country appears in this issue of *THE MODERN HOSPITAL*. This exceedingly practical set of rules for the heating plants of small and large hospitals was prepared at our request by the United States Fuel Administration. If there were no war, these instructions would still be most valuable, because their observance means clear saving in fuel. As it is, they should be enthusiastically welcomed by the hospitals of the country.

THE HOSPITAL—PAST, PRESENT, AND FUTURE*

Changed Attitude of the Public Toward the Hospital—Reasons for the Greater Confidence Felt in Hospitals by the Public—Future of These Institutions

By A. S. MONRO, M.D., Major C. A. M. C., Director of The Vancouver General Hospital, Vancouver, B. C.

It is within the memory of most of us, and I need not go back more than two decades to recall the great change that has taken place in public opinion towards the hospital. Then it was a matter of life or death, such as a severe accident or illness that required surgical treatment, that compelled the unlucky one to be sent to hospital. How the friends and neighbors talked about it and commiserated with the relatives. Or perchance the sick one had no home but belonged to the great army who have no settled abode, and then of course the hospital was the only place for him, but how he was pitied!

No self-respecting woman, however much she dreaded the coming ordeal of maternity or the upsetting of her household resultant upon its advent would entertain for a moment the suggestion of going to the hospital. The hospital was only for the outcast and the unfortunate.

To ask parents to place their children in the hospital for the purpose of having, say, an operation for removal of the tonsils done or any other common affection was often sufficient to bring about an immediate change in medical attendants, and the physician who had the temerity to propose such a thing became the subject of adverse criticism by the community at large.

Public opinion, however, was not altogether wrong in the attitude it assumed towards hospitals. The facilities offered by many of them for the care of the sick were no better or even as good as that approached by a well appointed home. The accommodation in many institutions provided only for the homeless, the unfortunates or those who required a major surgical operation, and even in the latter case, if the patient had a good home, every effort was made to have the operation done there rather than go to the dreaded hospital.

It was not uncommon in this city no longer than fifteen years ago to see major operations performed at the home of the patients. As for the minor ones, only the last five years has seen them transferred from the home to the hospital. What, then, has brought about this marvelous change of opinion in the public mind toward the hospital? The change is due to *better service*.

The factors most influential in molding public opinion were:

1. Improved accommodation. This meant new buildings that provided for all classes of the community, the private room, semiprivate and semipublic beds, and better general wards. The hospital, no longer dull and dreary, now took on the aspect of a comfortable home, and the patient was made to feel his stay in the hospital would be as pleasant as circumstances would permit. The dietary is in the hands of a specially qualified dietician, and, when his condition permits the patient can have as varied a meal as may be obtained in any well-appointed restaurant.

2. Better nursing. Of more importance even than accommodation is the quality of the nursing service provided. In this respect the public feels that a high estate of efficiency has been reached in the nursing profession and has shown its confidence by demanding not only in the hospital but in the home the elimination of the un-

*Paper read at the First Convention of the Hospital of British Columbia, June 26, 27, 28, 1918.

trained nurse. Some nurses are better adapted for certain work than others. In the hospital this specialization of service is carried out to a large extent, and the larger the institution the greater the need of it with consequent advantage to all concerned. The public understands and appreciates the advantage of this.

3. Better scientific equipment. Advance in medical and surgical science, requiring expensive equipment and laboratory facilities only to be found in connection with modern hospitals, has been an important factor in the influencing of public opinion in favor of the hospital. A hospital composed of buildings, beds, furniture, etc., and without up-to-date laboratories, x-ray departments, and operating rooms, is nothing more than a glorified boarding house. The public appreciates the value of these essential features in a hospital, and consequently those who are sick are not only willing but anxious to go where the fullest facilities are offered for getting them well. The people are learning that the essential preliminary to intelligent treatment is a correct diagnosis, and in many cases it is necessary to go to the hospital to have this made.

In the treatment of disease the use of medicine or the knife is not the only means or even the most desirable in many cases. We know that the x-ray, radium, electricity in various forms, hydrotherapy, thermotherapy, and massage are essential to successful results in the treatment of many of the ailments. This demands an expensive and costly equipment, and the hospital is the place to which the public looks to provide these facilities. Above all, the motive animating those who are responsible for the care of the sick from the hospital director down to the humblest orderly is one of *service*. No hospital, however well equipped and staffed, can do its best work without this atmosphere of service mingled with a spirit of kindness and sympathy pervading the entire institution.

The future of the public hospital and the place it will occupy in the esteem of the community in which it is located will depend largely upon the quality of service it can render to those who require it.

The system under which the public hospitals of British Columbia are conducted offers, in my opinion, many advantages over the purely municipal or civic control.

The remedy for a poor service in any community is directly in the hands of the people in that community, but at the same time a closer supervision by the state of all hospitals would undoubtedly lead to a higher standard of efficiency generally.

The war has brought about so many radical changes that state control of many of our most vital necessities is now accepted by the public as a matter of course and without question. Who will venture to predict the permanency of these changes in the period after the war and what will be their effect upon the relation of the hospital to the community? A beneficent socialism that would provide, at the expense of the state, for the care of all the sick and injured is as yet too utopian for realization, but the trend of events are along these lines; witness the British Medical Insurance Act.

In this young country, as well as in the older centers, the hospital will be required to provide a larger and better service, and it is not too much to say that the day is not far distant when all but the minor and the most trifling ailments will be cared for in the public hospital. The advantages of such a system from an economic point of view are manifest. The saving in time and cost alone would be immense, to say nothing of the added gain to the patient in being enabled to recover from his sickness in the shortest possible time.

THE MEMOIRS OF A HEAD NURSE

V.—An Officer and a Gentleman—A Little Lad of Eight Who Proved That Blood Tells After All

This is a hospital story because it ends in a post hospital, but, to have you really understand the Boy, I shall have to begin before the hospital part of it.

He was about eight years old then, a strong strapping little fellow with a soldierly body and a shock of brown hair that would never stay brushed. He belonged to a fine old family. His mother was a niece of one of the admirals you had to learn about in United States history when you were in the seventh grade, and his father came of a long line of army people. They had been army people before '76—the army was in their blood, so you can understand why I am so sure of where he is now, if he is still alive.

I was teaching in those days, and Webster, when I first made his acquaintance, was a pupil of mine. I have never forgotten the sterling character of the boy, his never-failing respect and courtesy, and his genuine bravery. He was an officer and a gentleman always.

He was terribly handicapped in the schoolroom by stuttering, but this was more than balanced by a ready wit and keen intelligence. This story happened before the "swat the fly" days, and one day during the class hour, when we came to a story in the reader which pleaded with children not to hurt or destroy anything that lived because God had made it, Webster said, "That m-m-may be true about fl-fl-flies, but you can never m-m-make me believe that G-G-God made m-m-mosquitoes."

His father was a captain of artillery at the post, and was going down fast, physically and mentally, from drink. His mother, a gentlewoman to her finger-tips, too proud to complain, endured constant humiliation in her own home, and must have breathed a sigh of infinite relief when the captain was buried with full military honors in Arlington cemetery.

Somehow or other, Webster seemed to be the only one who could bring a sense of decency to the captain when he was drunk and abusive. One day, in the midst of a lesson, we heard him in the hall, cursing and swearing, and the soft voice of Mrs. C. trying to quiet him and to keep the sound of the disturbance from the neighbor's ears and mine.

Webster stood up. "Please may I be excused, Miss R?" he said, and went into the hall, closing the door tightly after him. This is what we heard through the closed door, and I could almost see the boy, standing at attention, as he always did when he addressed his father or any superior officer.

"Captain C.!"

"Yes, sergeant."

"That is my m-m-mother you are t-t-talking to."

"Yes, sergeant."

I could hear the click of the captain's spurs as he turned on his heel and walked away. A blessed silence fell and Webster came back into the room again, closing the door softly behind him. He took his place at his desk and the lesson went on.

There had been two older sons, and there was an astonishing difference between their ages and those of the two younger boys whom I was teaching at the time.

The older, a young lieutenant at a southern post, had inherited his father's taste for liquor and just before I had known them had committed suicide there for the love of a beautiful young divorcee who didn't give the snap of her finger for him.

The younger, a lieutenant, too, fell at San Juan Hill, a brave soldier and a gentleman to the last, sacrificing himself for the safety of his company, they said. The captain, the boy's father, redeemed himself there too, and died soon after the Spanish-American war, worn out by grief and drink.

But to come back to my story and Webster again. The old regimental bugler had taught him to play the calls and the battery had presented him with a bugle when he had learned them. It had a long red cord and tassel on it. Every morning, as I rounded the driveway to the officers' loop, a soldierly little figure would appear in the doorway of the captain's quarters blowing the school call, and the day that I left the reservation the same sturdy figure stood in the doorway and blew taps for me.

Fort _____ was on a high bluff over the lake. Between the officers' loops were deep wooded ravines. One of these had a road in it, making an even incline down to the lake shore, and in the winter, an ideal place for bob-sledding.

Webster had a girl, even at this early stage. I remember she had very blue eyes and a lot of gold curls, and was a little younger than he was; about half past seven, I think. You couldn't imagine a prettier sight than Webster and Blossom sledding down that ravine in their red caps with the snow and the big pines for a background.

One day, during the Christmas holidays, to avoid running into some other children on a sled ahead of him, Webster crashed straight into a big tree stump. He got up, told Blossom to take the sled home, and walked about three blocks to his quarters, went upstairs, undressed himself and went to bed. He waited till he heard his mother pass the door of his room and called her in. "Mother," he said, "I think I am hurt, will you please call the major surgeon?"

After the major surgeon had examined him, he said, "Good Heavens, child, did you walk all the way home?"

"Yes, sir."

"And you didn't cry when you were hurt?"

"No, sir; you see, Blossom was on the sled, and I c-c-couldn't cry before a g-g-girl."

The major surgeon carried the boy very tenderly to the post hospital, and they tried to repair the damage. By this time the news had spread through the post that Webster had been badly hurt, and excited groups of soldiers were standing about the barracks and the drill ground demanding news of their small comrade, whom they all adored.

At the hospital, when they put the boy on the operating table, the major surgeon said to him, "I'm going to have the doctor here give you something to put you to sleep, so that you won't feel anything."

"Oh," said Webster, "that's the stuff that makes you so s-s-sick to your s-s-stomach. If you please, sir, I would rather stay awake if you don't mind."

"But you newer in the world can stand what I have to do to you without an anesthetic, and you couldn't keep still enough."

"Oh, yes I can, sir, if you will just go s-s-slow and do the best you can not to hurt; I won't move a b-b-bit or cry or do anything to bother you; you just t-t-try me, sir, please."

So he lay quite still and never even cried when the major surgeon dug out, from less than a half inch distance from his spine, and from a depth of two inches, a collection of cloth and underwear and a big piece of wood from the bobsled, and the splinters that had broken off and driven themselves into the flesh.

For a week after that we had a mighty sick boy on our hands—so drowsy and feverish most of the time. The doctors were worried and the regimental chaplain, a priest at this time, had special prayers said in church for him, and many a rosary was said by soldiers who usually went to church only when they had to.

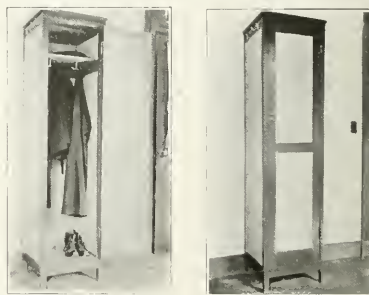
At any rate, either because of the prayers or because we could not spare him, Webster got well, and stood straight and strong again, and if he is alive today I know that he must be in this war somewhere. And I'll bet he doesn't drive his men as the German officers do, but he will be the first over the top, with his head held high, calling his men to follow, even if he stutters while he does it.

INEXPENSIVE AND SERVICEABLE WARDROBES

How Burke Foundation Has Solved the Difficulty of High-Priced Building Material

By MARY R. RUHL, Supervisor of Occupation, The Burke Foundation for Convalescents, White Plains, N. Y.

Wood wardrobes are always discouragingly expensive for "what you get out of them." Metal lockers, if in size to be effective for wardrobe use, are well-nigh prohibitive in price. Yet there are many places in hospitals where built-in closets are not available or feasible, for various



Compo-board wardrobe, open and closed.

well-known reasons. Especially is this true in adaptation of quarters, as experience has proved. Closets often come in the way of right bed-placing and capacity.

To overcome this difficulty, we make small wardrobes of compo-board in the patients' workshop which are very satisfactory. The frames are of cypress or pine 1½ inches square and grooved ¾ inch deep to take the compo sides and back. The usual measurements are: height over all, 6 feet 5 inches; legs for cleaning, 4 inches; cross-section, 18 or 24 inches square; cypress shelf, ¾ inches and 11 inches from top to give large hat-room; hooks under shelf and on corner posts—also on outside frame if needed (towel rods have also been screwed on outside).

The wood is usually painted dark buff and the compo lighter. The wardrobes look well. One serves two or three convalescent patients adequately, and the larger size is used in employees' rooms. Many will be made and used here.

The cost, including handicapped labor at 20 cents per hour, is about \$6 each. Some saving could be made by nailing the compo on the frame instead of grooving in, but the result would be inferior. Size, shape and detail may be variously modified to fit individual need.

INDUSTRIAL REHABILITATION OF DISABLED SOLDIERS AND SAILORS

Conducted by ELIZABETH G. UPHAM.
Director Art Department Milwaukee-Downer College.

BLINDNESS A TEMPORARY DISABLEMENT

Soldiers Who Have Lost Their Sight Quickly Fitted to Assume Remunerative Positions in Civil Life—Ideal Atmosphere Characterizes Rehabilitation at St. Dunstan's—Cheer the Keynote

BY MRS. SIDNEY McCALLIN, a Worker with the Staff of St. Dunstan's Hostel in London, England.

Nineteen fourteen is associated in the epochs of history with the most intense suffering and the greatest reconstructive progress the world has ever witnessed. A man gives his sight for the humanity of the world, and reconstructive work has proved that the world has happiness to give him in return. Forget the figure of sadness, the blind and lonely musician, fiddle and alms-cup in hand, for whom the world, in its ignorance of life's possibilities, has known but pity. It was the thought of this figure which inspired a great man—a man pecu-

liarily suited to the task—to establish St. Dunstan's, the magnificent institution which was to render such a plight impossible for Great Britain's soldiers and sailors.

Sir C. Arthur Pearson, Bart., himself a blind man who had lost his sight directly previous to the declaration of war, perceived in the reclamation of the blind the possibility of a great field, and America, through the generosity of Mr. Otto Kahn, of New York, had the privilege of extending a helping hand in the enterprise by supplying necessary quarters for this home.

The institution was founded to meet the need of rehabilitating about forty men. The hostel now accom-



FIG. 2. The class in typewriting at St. Dunstan's Hostel.

modates, in the original house and its various annexes, over five hundred. Up to the present time between three and four thousand men have been graduated from its various departments, fully equipped to take up life anew.

Let us, in imagination, follow the progress of one of these interesting characters through the period of time—from twelve to fourteen months, as the case may be—in which he takes the first great step in his new life in the blind world.

Nestled in the fresh greenery of Regent's Park and guarded by the grim, grey spires of London, is St. Dunstan's. It is here that our blind man goes to begin life over. Not an entirely strange world it is to which he comes as he enters his new home, for, from the time he has found himself in bandages, lying in a military hospital, he has been visited by representatives of the staff of St. Dunstan's, and he himself has made occasional visits to the hospital during his convalescence. Amid the welcome of the staff sisters, who are members of the Voluntary Aid Detachment of the British Red Cross, he finds it a pleasure to learn that he is to be completely outfitted with necessary clothing and given a Braille watch with which he can tell the time by touch, and that he is to be able, in a personal interview with the chief himself, to choose his future vocation. In his new environment he might question his ability to be independent, but he is pleasantly surprised to find that it is with comparative ease he makes the first tour of inspection. He learns that, if he be a Scottie, other kilties will sit with him at the table; or that if, by chance, he has come from the Land of the Maple Leaf, brothers from over the water will be beside him. Suddenly he perceives that he is walking upon a pathway of linoleum flanked by strips of carpet. By this time he has realized that there are turnings in the pathway which lead him to boot-room,



FIG. 1. Sir Arthur Pearson, the publisher, who lost his sight before the outbreak of the present war, and who has founded St. Dunstan's Hostel for the rehabilitation of blinded sailors and soldiers.

barber-shop, work-room, and other apartments of the building, among which is the inner lounge, where he is greeted by varied sounds. His ear distinguishes between the ticking of several typewriters and the buzz of conversation, indicating the fact that the boys are entertaining their friends. He is told that a four at Braille dominoes are having an exciting game, and that the piano in a far corner is being played by a blind pianist to while away the time for those who might feel dull. Besides being taught Braille, so necessary to the blind, every St.



Copyright by Western Newspaper Union Photo Service.
Fig. 3. Corner of carpenter's and joiner's shop at St. Dunstan's.

Dunstan man learns the use of an ordinary typewriter, with which he is provided upon leaving the hostel.

Our blind man has his choice of the following vocations: a full training in massage, including pathology, which equips him to be of service at the present time in military hospitals and later on in private practice; poultry farming, which takes him into the art of the rearing and disposition of stock; and carpentry, with a department for picture-framing, which includes the fabrication of simple furniture and trays. This last department is taught by a blind man. Cobbling, which is of use to men living in small towns, is also taught, and basket-weaving is being done the world over by the soldier-blind with as much efficiency as by the civilian who has lost his sight. Liberty & Co., with its high-class reputation, sells the fiber mats made at St. Dunstan's, and Gamage & Co., of London, sells St. Dunstan's twine hammocks. This fact in itself speaks for the efficiency of these departments. Braille shorthand and telephone operating are being taught to some extent. It is of interest to realize that, in his establishment of the trades taught here, Sir Arthur Pearson has not in any way encroached upon the fields already occupied by the civilian blind.

But "all work and no play makes Tommy a dull boy," and please don't think of our blind man as dull, for in reality he whistles and sings throughout the day. Nine o'clock finds our men assembled to hear the important news of the day read from the daily paper. From nine-thirty to twelve and two-thirty to four-thirty they are in the work-shops, with a happy intermission at noon, during which time there is a bit of dancing if the Cold Stream Guards Band is at hand, and if not, a walk around Regent's Park with an interesting companion, or perhaps a trip to town to do a bit of shopping. On the evenings when nothing exciting is planned it is not an un-

usual sight to see many couples making off to near-by tea-shops or going out in groups for an hour's motoring. Often a theatrical company from the West End of London comes out to entertain what they consider the most appreciative audience in London; or occasionally an hour of choice music is enjoyed by the "boys."

After supper our happy family gathers around its own fireside and its members enjoy the privilege of entertaining each other. Many a fiery debate based on current events takes place, and occasionally Sir Arthur Pearson himself is a delighted listener. A rare Welsh voice is often heard, and on very special occasions St. Dunstan's rag-time band is induced to play. The members of the band, with the exception of the pianist, are all blind. During these concerts one frequently hears a faint click here and there among the audience. Every smoker is in possession of a tiny tin box into which, out of



Copyright by Western Newspaper Union Photo Service.
Fig. 4. Blind men at St. Dunstan's learning to make door mats. Liberty & Co. sells the fiber mats made here.

consideration for the sister responsible for the spotlessness of the assembly room, he drops his match-ends and ashes.

In the winter months directly previous to the Christmas holidays, the Christmas pantomime is usually rehearsed under the capable direction of St. Dunstan's quartermaster, an artist in his profession.

It is not fair to leave our versatile character without mentioning the sports which play such an important part



Fig. 5. Shoe-making shop at St. Dunstan's.

in his life. With the coming of spring, the gymnastic drill which is of such help during the winter months is abandoned, for, throughout England, this season ushers in one of the most favorite sports—rowing. And so we find him practicing on the Regent's Park lagoon, in preparation for the contest for possession of the silver cup.

Let it be thought that the care of the men ceases with their graduation from the hostel of St. Dunstan's, it is interesting to know that an after-care department has been organized, whose members keep track of the men



Fig. 6. St. Dunstan's rag-time band, with some of the sisters. All the members of the band with the exception of the pianist are blind. Note the happy expression on the faces of all the men in this and the preceding pictures.

wherever they may be and see to it that their shops are properly situated, that their homes are satisfactory, and that their materials reach them in good order.

It is at home that the blind man most appreciates the remarkably fine teaching he has received in the Braille department at St. Dunstan's under a commandant of exceptional understanding and her staff of capable teachers and the system which keeps him in touch with the unusually fine Fully Contracted Revised English Braille Library in London.

And now you will perhaps say, "What can I do to help this great cause in America?" You may not know that there is in the United States a fully organized institution similar to St. Dunstan's. In addition, there is an organization entitled the A. B. F. B. (American, British, French, Belgian) Relief for Blinded Soldiers and Sailors, which has pledged vast sums to France, which is now helping St. Dunstan's, and which stands ready to act as a medium for the aid of our American men. And as America so willingly stretched out her hand to help the blinded soldiers and sailors of Great Britain, let her now prepare to do as much and more for her own.

* * * *

WHAT ONE STATE IS DOING

How Pennsylvania Is Planning to Help Its Soldiers, Sailors, and Marines Crippled in War Service

In the Bureau of Employment of the Pennsylvania Department of Labor and Industry, at Harrisburg, extensive card files, recently installed, indicate where 42,111 soldiers, sailors, and marines, crippled or permanently disabled through war service, may find in Pennsylvania suitable employment despite their various disabilities. More than one-half of the 42,111 employment openings, in virtually all sections of the commonwealth, are in skilled tasks that

may be performed by men having lost one or both legs, an arm, or who are handicapped by other disability. Places of employment range from steel mills to dairies, from silk mills to railroads, from cigar factories to paper mills, and from lumber camps to department stores. The great number of employment opportunities for crippled war veterans are classified in the bureau of employment by industry, by locality, by occupation, and by disability of workers to be employed. This classification has been made possible by the patriotic responses of Pennsylvania employers to a questionnaire sent state-wide from the Pennsylvania Department of Labor and Industry early this year.

On March 1, the total number of employment openings so classified was 30,710. This number has increased to 42,111 to May 1, and is constantly growing, as replies are still being received. Every Pennsylvania employer who can give employment to war cripples handicapped by various disabilities is urged to notify at once the department of labor and industry, Harrisburg.

The report of the progress of this work in Pennsylvania, the first state in the Union to cooperate actively with the national authorities in the effort to prevent war cripples from being shunted merely into by-product industrial tasks, was submitted to Acting Commissioner Lew R. Palmer, of the department of labor and industry, by Jacob Lightner, director of the bureau of employment. The chairman of the Pennsylvania State Committee on Reconstruction, Reeducation and Reemployment of Crippled Soldiers, Sailors, and Marines, recently appointed by Governor Brumbaugh, is Adjutant General Frank D. Beary; the committee, which includes Acting Health Commissioner B. Frank Royer, Acting Commissioner of Labor and Industry Lew R. Palmer, and Dr. J. George Becht, Secretary of the State Board of Education, has general supervision of the reconstruction program for the commonwealth.

The national authorities are planning to equip each disabled soldier and sailor with every suitable appliance to bring his physical efficiency to a maximum and to give him suitable treatment and training to adapt him for the tasks in industry he can most advantageously perform. From the classified employment lists of the department of labor and industry, each Pennsylvania soldier, sailor, and marine disabled in war service will be able to obtain, from thousands of openings in his home state, a task for which he is best suited physically, a task that will give him greatest financial return according to his capability and probably in the city or town where he most desires to reside.

The questionnaire sent to employers by the department of labor and industry designated thirty-eight general classes of disability which might result from war wounds to handicap the soldier or sailor when he desires to engage in industrial work. These disabilities include loss of one or both of the upper extremities in whole or in part, stiffness of the upper extremities in whole or in part, loss of one or both of the lower extremities in whole or in part, blindness of one or both eyes, deafness of one or both ears, loss of speech, repulsive facial disfigurements, hernia and general health impairment which would prevent heavy manual labor.

The complete list of employment openings in Pennsylvania, tabulated in the bureau of employment from replies received up to May 1, according to the various classes of disability, are as follows:

Disability	Number of openings
Loss of fingers.....	One hand..... 451
	Both hands..... 729
Loss of hand at wrist.....	One hand..... 458
	Both hands..... 3
Loss of arm below elbow.....	One arm..... 374

Loss of arm at shoulder.....	Both arms.....	328
Stiff finger-joints.....	One arm.....	2,321
Stiff wrist-joint.....	Both hands.....	2,014
Stiff elbow-joint.....	One arm.....	499
Stiff shoulder-joint.....	Both arms.....	897
Partial loss of foot.....	One foot.....	72
Loss of foot at ankle.....	Both feet.....	521
Loss of leg below knee.....	One leg.....	80
Loss of leg at knee.....	Both legs.....	2,149
Loss of leg at middle of thigh.....	One leg.....	599
Loss of leg at hip-joint.....	Both legs.....	1,074
Stiffness of lower extremities.....	One leg.....	401
Blindness.....	Both eyes.....	993
Deafness.....	One ear.....	175
Loss of speech.....	Both legs.....	649
Repulsive facial disfigurements.....	One leg.....	73
Hernia.....	Both legs.....	491
General health impairment, preventing heavy manual labor.....	One leg.....	52
Miscellaneous.....	Both legs.....	795
Total.....	One eye.....	48
	Both eyes.....	432
	One ear.....	113
	Both ears.....	4,021
	Both eyes.....	3,642
	One ear.....	501
	Both ears.....	2,981
	Both eyes.....	5,783
	One eye.....	400
	Both eyes.....	1,321
	One eye.....	1,558
	Both eyes.....	42,111

Second Annual Meeting of the National Society for the Promotion of Occupational Therapy

The business meeting was held on the morning of Labor Day. In the afternoon a visit was paid to the splendid workshops at Bloomingdale Hospital, where Dr. Russell sketched the history of the institution in a short address of welcome, after which tea was served and the shops visited. The scientific session was opened on Tuesday, September 3, with a paper on "The Principles of Occupational Therapy," by Dr. W. P. Dunton, in which he urged that the society formulate the fundamentals of the subject for the guidance of beginners in the work. A committee consisting of Dr. W. L. Russell, Mrs. Eleanor C. Slagle, and Mr. Norman L. Burnette was appointed for the purpose of making up a report, which will appear in the October number of the *Maryland Psychiatric Quarterly*.

Miss Evelyn L. Collins spoke on "The Remuneration of Teachers," and a committee was also appointed to bring in recommendations on this subject. Some of those present seemed to fear that this might be regarded as an attempt to unionize although it had been clearly expressed that the purpose of introducing the subject was that teachers might be accorded a proper recognition and that hospital superintendents might have some criteria for action. In such a report, it is necessary to consider a number of factors, such as hours of duty, maintenance, training and experience, number of pupils, etc., all of which it is hoped will be given proper value by the committee.

Dean Russell of Teachers College, in a stimulating address, requested that the society determine the minimum requirements for a course of training for occupational aides. The board of management is at present working on this matter, and their recommendations will appear in the October *Quarterly*.

During a pleasant visit to the Red Cross Institute for Crippled and Disabled Men on Tuesday afternoon addresses were made by the assistant director, Mr. H. R. Hayden, who outlined the work of the institute, by Miss Randolph, who described the speakers' bureau, by Miss Bulliss, who told of the industrial surveys which had been made under her direction, and by Miss Stein, who spoke of the placement of cripples by the employment bureau. Much interest was shown in Mr. Kidner's address Tues-

day evening on The Work of the Canadian Invalided Soldiers Commission, which was illustrated with three reels of pictures. Miss Susan C. Johnson gave an interesting description of work at the Montefiore Home, illustrated with lantern slides.

On Wednesday morning the subject of training courses was discussed by Miss Susan C. Johnson, Mr. N. L. Burnette, and Mrs. E. C. Slagle. In her paper Miss Johnson spoke of the desirability of standardizing products in order that there may be an improvement in the design and utility of the products of patients' labor. Mrs. Mary J. Sullivan, formerly connected with Pratt Institute, was appointed chairman of a committee to take charge of this matter.

A visit was then paid to the Clinic for Functional Re-education of Disabled Soldiers, Sailors and Civilians, at 5 Livingston Place, where Dr. W. Gilman Thompson escorted the members about the institution and explained its workings.

The afternoon session was opened by a paper by Dr. S. Wachsmann, of the Montefiore Home, on "The Remuneration of Patients." Although the speakers agreed with many of the excellent ideas advanced by Dr. Wachsmann, the paper provoked considerable discussion. A committee was appointed, as suggested by Dr. Wachsmann, to consider the subject and report to the board of management.

The enthusiasm and satisfaction of those attending were evidences that the meeting had been quite worth while, and an excellent attendance testified to the interest which is being taken in the subject.

The third annual meeting will be held in Chicago on the second Monday in September, 1919.

Wherever we are, however near the end of our running, it is never too late to resolve that high thoughts and brave qualities shall accompany us for the rest of our journey. Such resolves may be easier for those who have made them before and carried them out; they are, undoubtedly, more difficult for those who have made them before and then turned slothful and let them slide out of grasp; but what is worth while to bear in mind is that beginning again is never impossible; the field of effort is open and who sets his will to work may achieve.—Harper's Weekly.

Today, whatever may annoy,
The word for me is Joy, just simple Joy:

The joy of life;
The joy of children and of wife;
The joy of bright blue skies;
The joy of rain; the glad surprise
Of twinkling stars that shine at night;
The joy of winged things upon their flight;
The joy of noon-day, and the tried
True joyousness of eventide;
The joy of labor, and of mirth;
The joy of air, and sea, and earth—
The countless joys that ever flow from Him
Whose vast beneficence doth dim
The lustrous light of day,
And lavish gifts divine upon our way.

What'e'r there be of Sorrow
I'll put off till Tomorrow,
And when Tomorrow comes, why then
'Twill be Today and Joy again!

—Atlantic Monthly.



Conducted by BARROW B LYONS
Superintendent Delaware Hospital, Wilmington, Del.

Proposed Federal Control of Industrial Welfare

Industrial medicine and surgery on a more extensive scale will be vigorously advocated by the Federal Government provided the Senate Joint Resolution No. 63 is passed by the House of Representatives. This bill is framed to provide the personnel necessary to a national campaign to promote such work.

The permanent benefits which will result from this work, provided the proposed bill becomes a law, judging from recorded experience, would be so evident both to labor and employers of labor that a permanent expansion in the field of industrial medicine and surgery would result.

Today "big business" realizes the value of maintaining the efficiency of the human machinery; but "big business" exhibits greater intelligence than industry in general. Whether or not Senate Joint Resolution No. 63 is passed, manufacturing concerns, large and small, will soon recognize the necessity of carefully providing for the physical well-being of employees to a far greater extent, especially if health insurance laws are enacted in many state legislatures.

These great changes will have a profound effect upon the organization of our hospitals, for they will tend to take away more and more "business" from the private practitioner and bring it to institutions. How is the physician and surgeon to be compensated? To what extent will existing hospital facilities be used in this work? How will the present hospitals be affected by the inevitable increase of company hospitals organized by industrial concerns to care for their own injured?

In order to answer these questions wisely, the hospital executive must study the problems of industrial welfare and keep pace with the great spirit of the times which is transforming self-interest into service. Every hospital has a service to sell to the industrial concerns in its neighborhood. Ability to make this service attractive and market it to good advantage will largely govern the success of many hospitals in the future, especially those located in or near industrial sections.

The hospital superintendent who possesses vision, courage, and the practical common sense to transmute his vision into fact will be able to seize this opportunity for service and with it benefit all in his community.

Industrial medicine and surgery often has been found to be the key to problems between capital and labor. It has served to increase the production and decrease the cost of production in a number of mills and factories, and at the same time to promote the health and happiness and actually increase the wages of the workers. It has served to promote loyalty of the workers and greatly decrease the waste of a large labor turnover.

This is a field of hospital activity which is in its initial stages of development only. Hospital executives by keeping closely in touch with the great expansion in industrial medicine now taking place may find new and perhaps unthought of possibilities of service opening before them.

* * * *

MORE SHIPS FROM HEALTHIER WORKERS

The Great Welfare Task Undertaken by the United States Shipping Board Emergency Fleet Corporation

The most tremendous industrial welfare program ever undertaken has been launched under the auspices of the United States Government for the workers engaged in building ships. Under the guidance of Lieut. Col. Philip S. Doane, M. C., N. A., director of health and sanitation for the United States Shipping Board Emergency Fleet Corporation, standards of surgical and medical attention for the hundreds of thousands of men working on merchant vessels for the government are being enforced.

Not only does Colonel Doane prescribe the standards for first-aid and surgical treatment, but he must see to it that the men in 171 shipyards, dotted along the entire coast length of the Atlantic, Pacific, Gulf, and Great Lakes of this country, live and work under sanitary and healthful conditions. He holds himself in large measure responsible for good housing conditions, clean restaurants, and pure water supply.

In every spot where ships are being built for the government he is seeking to cooperate with local authorities in creating sanitary living conditions for the shipbuilders. With the help of the state of Pennsylvania, the city of Philadelphia, and the Westinghouse Electric and Manufacturing Corporation, he drained, mowed, and sprayed with oil in order to exterminate mosquitoes, fifteen square miles of marsh land surrounding the great Hog Island shipyard in which 30,000 men are employed. This was done because the many electric lights used by the night shift attracted such hordes of insects that it was impossible to get much work from the night men.

A NEW MANUAL OF WELFARE STANDARDS

One of the first steps Colonel Doane took in establishing better conditions in many of the 168 shipyards was the publication of printed standards covering the examination of workers, medical treatment, sanitation, restaurants and lunch rooms, and housing conditions. This little booklet, because of its application to so many shipyards, is one of the most important set of health welfare standards ever established. It contains information which would profit almost any industrial concern. In the introduction to this book Colonel Doane says:

"A healthy and energetic force of workmen is as essential to the speedy construction of the ships as a well-laid-out yard, prompt delivery of materials, labor-saving machinery or efficient methods of work.

"The building and operation of ships by the U. S. Shipping Board Emergency Fleet Corporation is the greatest industrial task ever undertaken, and, being a governmental activity, the hygienic and sanitary standards under which this work is carried on should be worthy of adoption by private industry.

"The health of the workers also has a very direct influence upon the cost of building ships, for a dollar's worth of work should be obtained for every dollar paid in wages. This is not possible with employees in ill health or with lowered vitality.

"To obtain such conditions it is necessary that the principles of industrial sanitation as established by actual

practice shall be as clearly understood and strictly conformed to. This requires the expenditure of funds, but experience has clearly demonstrated that the investment pays dividends.

"The enormous increase in the shipbuilding industry to meet war needs has caused a constant influx of workmen into the shipyards who are unused to the rigor and exposure of shipbuilding. This condition demands unusual care to safeguard their vitality."

Every shipyard coming under the jurisdiction of the Health and Sanitation Department must provide surgical and medical attention according to the size of the plant. In some of the very small yards in which only a few hundred men are employed a first-aid kit suffices when a

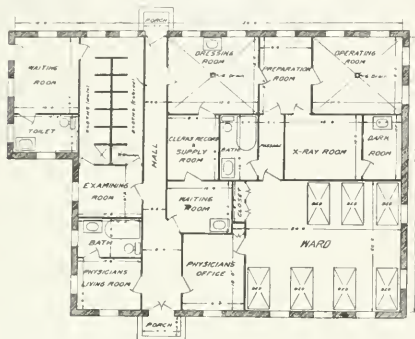


Fig. 1. First Aid Station planned for small firms by Dept. of Health and Sanitation, U. S. Shipping Board, Emergency Fleet Corporation.

physician living in the neighborhood of the plant is on call. Figure 1 illustrates the requirements called for by the manual of standards for plants employing from 1,000 to 2,500 men, and Figure 2 shows the plan suggested for firms employing 5,000 men or more. The department recommends that, in addition to the facilities shown in the cut for a first-aid station, space be provided especially for the physical examination of employees. It is also recommended that, in the larger plant dispensary shown in Figure 2, a diet kitchen be provided when patients are kept over night and not simply moved to a larger hospital as soon as possible.

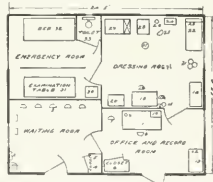


Fig. 2. Dispensary suggested for firms employing 5,000 or more.

BRINGING 171 SHIPYARDS INTO LINE

The extent to which each yard cooperates with the Department of Health and Sanitation of the United States Shipping Board Emergency Fleet Corporation depends entirely upon the size of the yard and the management of the plant. In the yards which are operating under "lump sum" contracts the Shipping Board has no direct financial responsibility. It simply recommends what its physicians and engineers think should be done, and, on the whole, this is carried out very well. Considerable control is exercised in most cases because the contracts state that the Shipping Board shall have control of the conditions under which ships shall be built.

In the "cost plus" yards it is a simpler matter. In these yards the government pays all the bills; so there is less hesitation upon the part of the managements in complying with our recommendations. If there is any

hesitation the Health and Sanitation Department simply tells the district officer or supervisor what it wants done and the order is given that it is to be done. An instance which illustrates this control occurred when the department gave orders that all of the employees in the yard of the Maryland Shipbuilding Company at Salus Point, Maryland, who would voluntarily be inoculated with typhoid vaccine should receive the injections.

There is another class of shipyard in which the department controls the situation more closely. These yards are primarily shipping boat yards, such as the Hog Island yard, which employs 30,000 men. In these yards the Emergency Fleet Corporation establishes its own dressing stations, hospitals and laboratories, and employs the men who are to operate them. Its own corps of sanitary engineers looks after the health conditions and, in some cases, its own housing experts plan and build dwellings for the workers.

The Hog Island plant carries its own workingmen's compensation insurance. In most of the contract and "cost plus" yards the Shipping Board has persuaded the insurance carriers selling liability insurance to provide their own physicians. Insurance companies have found that it puts many dollars into their own pockets to furnish their own surgical service.

REACHING OUT INTO THE COMMUNITY

When it comes to supervising the health of the communities in which the workmen live, a very difficult problem has been faced. If health conditions in a town are not satisfactory the Health and Sanitation Department first of all tries to get the local authorities to cooperate with them. It tries to get them to reorganize, furnish the funds with which to do their own job, and undertake their own housecleaning. If the department does not find cooperation forthcoming it tries to get the state authorities to assume control of the district. The United States Public Health Service can be called into cooperate with the state and city officials. In extrajurisdiction zones the Public Health Service can always be relied upon to help out, and it may be that extrashipyard zones in which the Public Health Service can be called upon to perform like services may have to be established. A good example of what can be accomplished when all forces work together occurred when city, state and Federal authorities helped to clean up the town of Alexandria, Va.

The control of venereal diseases is considered one of the most important problems, for these scourges not only cause many days of disability but tend to slow down the work of many men who are able to be on the job. Four methods of attacking the problem are being employed.

In the first place, at the time of examination, every man is given a little pamphlet called "Your Job and Your Future," printed originally for the army, which sets forth the plain facts regarding venereal diseases in a way which any workman who reads English can easily understand. In yards directly controlled by the Shipping Board, men who are apparently infected are given a special clinical examination; and this is urged in all plants indirectly controlled by the board. Special literature is given to men found to be infected in order to prevent them as far as possible from infecting other workers through towels, dishes, etc.

In the second place, a series of lectures given through the cooperation of the Council of National Defense has been started. Comparatively few men, however, have yet been reached in this way. Thirdly, the five-reel film, "Fit to Fight," which has been prepared by Colonel W.

O. Owen of the Army Medical Museum for use in the army, is being shown to the men in the yards. Finally, cooperation with the Bureau of Venereal Diseases of the United States Public Health Service is urged at every opportunity. According to Colonel Doane, Colonel Owen has helped tremendously in making the educational work along these lines effective.

PHYSICAL EXAMINATIONS FOR ALL WORKERS

Physical examination of all new employees is required in all yards, and the Department of Health and Sanitation urges that reexaminations be made every six months, largely because of the danger of venereal infections and possible tumors. In about three-fourths of the shipyards which directly or indirectly come under supervision of the department, first-aid stations, dispensaries, or hospitals have been established. In the remaining one-fourth, which for the most part are small plants building not more than one to two ships, there are first-aid outfits.

It is evident that a mighty task confronts the men who are directing this work and that, while much has been done, much still remains. Managers and workmen alike must, in many cases, be persuaded to cooperate more than they have yet done. In other cases, a strong hand must be used to force unwilling cooperation. Cities and towns must be cleansed, marshes must be drained, and hundreds of thousands of men must be examined and reexamined—all that more ships may be built.

The lesson may be applied by industries of all kinds, whether they direct their energies toward making tenting or ladies' pocket handkerchiefs. Each man released by a more efficient working force from making ladies' pocket handkerchiefs may be employed in making tents and blankets, or in the manufacture of munition. In addition, the benefit to the health of the working people is a permanent gain to the country which will outlast the war and continue into that tremendously important period which will follow, when American industries will be pitted against those of Europe in the most intense commercial competition that the world has ever seen.

MEDICAL INSPECTION JUSTIFIED

Statistics Taken in Two Inspectorates Show Work of District School Nurses Necessary

After one month's experience in medical inspection of school children attending rural schools in Saskatchewan, it has been demonstrated that the department of education is justified in the appointment of the two nurses who are now carrying on the work, and that additional nurses are necessary to extend the work. The figures compiled in two school inspectorates from the nurses' reports are taken as a fair indication of conditions prevailing in the other school districts of the province where no effort has yet been made outside of the cities and larger towns to inspect the health of the pupils. Thirty-five schools were visited and 742 pupils examined. Of this number, 241 were found without defects, 74 defective in vision, 21 defective in hearing, 240 with enlarged or diseased tonsils, 110 with adenoids, and 256 with carious teeth.

It is planned to extend the work by the appointment of twelve more district school nurses, and the estimates of the department of education at the next session of the legislature will provide for this expenditure. The idea is that eventually all the 41 school inspectorates into which the province is divided will have a school nurse.

"True patriotism is doing one's duty wherever that duty lies. Because of the shortage of assistants of every kind, sick and wounded are bound to suffer unless voluntary aid is offered."

MEDICAL EXAMINATION CARD SUGGESTED FOR GOVERNMENT LABOR RECRUITING AGENCIES

All Industries Throughout the United States Urged to Fit Their Employees to Jobs for Which They Are Physically Best Suited

Samuel Gompers, chairman of the Committee of Labor, has recommended to Secretary William B. Wilson of the Department of Labor that medical examination of applicants be made one of the functions of the government labor recruiting agencies.

This recommendation was the outcome of a conference under the auspices of the national sub-committee on welfare work of the Committee on Labor held in New York City July 15. The following resolution was adopted on that occasion. It embodies the consensus of opinion of experts on this subject, representatives of labor, employers, industrial physicians and public health workers.

"It is the sense of this conference that the physical examination of workers is primarily a measure of health conservation and also essential to maximum production—a war necessity.

"That the purpose of a medical examination is not to eliminate the worker from industrial service but to adapt him to the work he is physically fitted for. Therefore he it

"Resolved, in view of the public announced policy of the Government centralizing the recruiting of labor in the United States Employment Service, that this conference recommend that medical examination of the workers be one of the functions of the Government Labor Recruiting Agency.

"It further recommends the establishment of a central examination board, composed of representatives of the workers, employers and the Government.

"That this board issue examination cards indicating the health of the workers and classify according to physical fitness.

"Such a system of centralizing physical examination of workers does not prevent employers from maintaining their own system of physical examination and follow-up methods for the purpose of conserving the health of their workers."

It is intended that this should not prevent the employer from supplementing these examinations and pursuing certain follow-up or curative methods, after using the information thus gained, in placing men where they may be safely employed.

The Committee on Labor has had prepared and submitted with this general recommendation a proposed standard card to be used in making physical examinations, believing that the entire plan would prevent duplications both with reference to examinations and classifying and recording them. The opinion is also held that to have official examinations made by the Government would reduce about 50 per cent of the grievances resulting from such physical examinations when conducted by employers.

It is believed that by having an adequate number of physicians in each agency these examinations can quickly be made; in addition, communicable diseases will be detected, subnormal employees placed in occupations fitted to their peculiar conditions, spread of communicable sickness will be prevented, and employment of those who are below par made possible—all of which will greatly augment and help to maintain the health of our industrial army.

In indicating the possibilities of this plan Samuel Gompers said:

"There can be no question as to the wonderful effects that such a movement as here proposed will bring about. It is only a matter of education before employers throughout the country will come under this rule that people should generally be physically examined and that the examination should be standardized—at least the minimum.

"Well, we are thinking in such terms now as would have been impossible if we had not gotten into the war. I feel that we are going through a baptism of fire that will make for quicker and better thinking and a better

conception of life. It seems that in this world's history it has been clearly shown that no human achievement of a tangibly great character has ever been accomplished or ever will be accomplished except through a baptism of fire. It is the satisfaction of such achievement—and I have taken occasion to say that the newer conception of man's interdependence upon man; the establishment of new relations between man and man, as well as the new relations between nation and nation, and the question of the centuries, 'Am I my brother's keeper?' is being answered now, and answered in the affirmative. We are our brothers' keepers! You cannot help it; you cannot get away from it; the sluggishness of thought and the heavy handicap upon the feet of progress have been cut away and we are thinking more clearly and keenly and acting better in one comprehensive whole—first, to win this war, to root out autocracy, tyranny and injustice of all sorts, as far as it is humanly possible to wipe them out, and at last to give the opportunity for the development of a higher and better mankind."

The following is a copy of the proposed standard examination card:

MEDICAL EXAMINATION RECORD OF

Name.....	Address	Age.....	Sex.....	Married Single Widowed
Color.....	Weight.....	Height.....		
PREVIOUS OCCUPATIONS	REMARKS			
GENERAL APPEARANCE	Deformities			
SKIN	Malnutrition			
EYES	Glands			
	Diseases, Eruptions, Parasites			
	Vision) Right..... With Glasses) Left.....			
	Trachoma or other diseases			
EARS	Hearing) Right.....			
	Obstructed breathing (caused by)			
NOSE	1. Excessive number missing.....			
MOUTH AND THROAT	2. Excessive number decayed.....			
	3. Pyorrhea			
	Ulcerations			
	Other diseased conditions			
LUNGS	Abnormal physical signs			
	Diagnosis			
	Abnormal physical signs			
	Diagnosis			
HEART	Blood pressure			
	(See note)			
NERVOUS SYSTEM	Local paralysis			
	Epilepsy			
	Disease of nervous system			
EXTREMITIES	Deformities			
	Varicose veins			
	Flat foot			
	Hernia			
GENERAL	Hemorrhoids			
	Evidence of active venereal disease			
SPECIAL COMMENT	(Signature)			
	(Date of examination)			
LABORATORY DIAGNOSIS	Sputum			
	Tubercle Bacilli (if necessary)			
	Blood examination (if necessary)			
NATURE OF TREATMENT OR CARE REQUIRED .....	.....			
CONDITION ON RE-EXAMINATION	(Signature)			
	(Date of examination)			
EXPLANATORY NOTES: Make bold circle around abnormal conditions.	.....			
ADDRESS	Under this head inquire as to places of residence in preceding three months.			
PREVIOUS OCCUPATIONS	Inquire particularly as to exposure to hazardous occupations.			
GENERAL APPEARANCE	Note eruptions on skins, especially if communicable. Note presence of glandular enlargements of abnormal character.			
	Under Deformities should be included loss of a limb or of part of a limb, or the result of serious injuries or loss of eye and also faulty postural or spinal defect.			
EYES	Test vision with Snellen Test type, at a distance of 20 feet if practicable, or employ Snellen Reverse Type card placed beside applicant and reflected in mirror at a distance of 10 feet. When sight is defective and glasses are obtained to correct same, tests should be made with glasses to ascertain their adequacy.			
	Under Diseases note any opacities of cornea or other causes of defective vision, as well as infectious eye conditions.			

HEARING Test with ordinary dollar Ingersoll watch held at a distance of 2 feet from the ear. Under Disease note particularly chronic purulent otitis media.

TEETH Even when a relatively large number of teeth remain, note whether enough are in opposition for purposes of mastication. The presence of pyorrhea should be determined by making pressure on the gums.

MOUTH Note particularly presence of mucous patches of secondary syphilis.

LUNGS AND HEART..... Record physical signs that indicate evidence of abnormal conditions. Whenever practicable in examining persons of over 40 years of age, record systolic and diastolic blood pressure readings.

NERVOUS SYSTEM In examining for epilepsy note particularly presence of scars on tongue. Examine reflexes (ocular, knee jerks, and etc.) If there appears to be suspicion of nervous or mental disease.

EXTREMITIES The presence of disabling deformities should be particularly noted. Note especially varicose ulcers.

SPECIAL COMMENT Under this head it is desired that the medical examiner should summarize all the abnormal conditions found by him and make a plain and direct statement, indicating whether any of these conditions or all of them combined would tend to disqualify the applicant from general physical labor or from special forms of physical exertion.

A New Hospital for the Royal Navigation Company

The increasing number of employees of the Royal Navigation Company in Java made it necessary for this corporation to establish its own hospital. It is located on high ground and was commenced in 1914 and completed in 1916. The main building, destined for Europeans only, is a two-story structure, 76 meters long (about 230 feet). The corridor system permits ample classification and isolation. Each room has two beds, the rooms in the wings have from two to four beds. There is room for 78 patients in all. Special features are the wide and high windows of the first floor and the airy, covered gallery of the second floor constructed within the building. Behind the main building is the operating pavilion and the pavilion for natives with 72 beds. This hospital makes a splendid impression, and speaks well for the progressive spirit of the Dutch people. A full description accompanied by a number of fine photoprints appears in *Ziekenkuid*, Amsterdam, 1918, IX, No. 2.

Life is a series of surprises, and would not be worth taking or keeping if it were not. God delights to isolate us every day, and hide from us the past and the future. We would look about us, but with grand politeness He draws down before us an impenetrable screen of purest sky. "You will not remember," He seems to say, "and you will not expect."—Emerson.

Do today's duty, fight today's temptations, and do not weaken and distract yourself by looking forward to things which you cannot see, and could not understand if you saw them.—Charles Kingsley.

God has so arranged the chronometry of our spirits that there shall be thousands of silent moments between the striking hours.—Dr. Martineau.

The man who never makes mistakes never makes anything. Many chips, broken instruments, cuts and bruises, belong to the history of any beautiful statue.—Anon.



Conducted by ANNIE W. GOODRICH, Dean Army School of Nursing
and CAROLYN E. GRAY, Principal City Hospital School of
Nursing, Blackwell's Island, New York.

Please address items of news and inquiries regarding Department of
Nursing to CAROLYN E. GRAY, Principal City Hospital School of
Nursing, Blackwell's Island, New York.

THE STANDARD CURRICULUM FOR SCHOOLS OF NURSING*

**The Opportuneness of Its Publication During the Great
War—Its Value to All Interested in Supplying
Trained Nurses in Large Numbers for
Work Over-Seas and at Home**

By MABELLE S. WELSH, R.N., Assistant Dean, City Hospital
School of Nursing, Blackwell's Island, New York.

The profession of modern nursing has surely been tested as by fire in the year that has just passed. In spite of many efforts to break down our hardly-won standards, nursing is stronger than ever before. Growing originally out of the needs of war, it shows at the present time the value of the trained nurse as an indispensable adjunct of the military machine. It is agreed that "the trained nurse is playing a bigger part in this war than in any previous war," and also that "she is a trained and scientific worker, one to whom the government should give every possible authority and recognition." A representative just returned from a tour of the battle front, including the evacuation hospitals in Paris and some of the field hospitals, spoke enthusiastically of the devotion and faithfulness of the nurses in these hospitals. He said:

"My inspection of the front showed me that our great need in the hospitals is for more nurses and yet more nurses. Every possible means of getting recruits and training them should be used in this country. We can't get them over too quickly. And all legislation which helps the nurse and helps to make more girls want to be army nurses should be passed."

"I saw no more impressive sight during my trip abroad," said another Congressman, "than that of two young women nurses, quietly waiting in the station at Boulogne for the midnight train from the front which would be filled with wounded men. Tired and worn, as their faces showed, and bespattered, these girls waited there, quietly and patiently, to do their share in making the lot of the soldiers from the front a less painful one."

One of our own nurses in a recent letter tells of four thousand soldiers being received in a period of one week, and speaks of two hundred and sixty operations being performed daily after the recent fierce fighting. So much for the usefulness of our nurses abroad whom we are asked to enroll at the rate of "a thousand a week!"

Think what that means to us at home! Highly trained

women, training school superintendents, instructors, public health nurses, social service workers, withdrawn from our home work in large numbers! How shall we go on? It is obvious that we must train more and better nurses to fill our own depleted ranks, and to keep up with the ever-increasing military demands. It is difficult to provide this better training with our lessened staff of teachers and administrators, women who cannot be raised up over night, for our peculiarly technical work.

The institutions for higher education have come to our aid generously, the most conspicuous instance, of course, being the "training camp" at Vassar which is sending to our schools this fall four hundred young women, who have had a sound scientific preparation for nursing work. Two years from now we shall expect much from these young women.

Teachers College has given special courses for those who are qualified to teach in training schools and is planning further and closer cooperation with our schools this fall.

The Army School has triumphantly solved the problem of the nursing in our many cantonment hospitals, the story of which will be told in a later issue of this publication.

We have certainly never before so needed a standard which shall serve the training schools, struggling under extraordinary difficulties, through the sacrifice of their best to the military needs. It is fortunate that we have, at this particular time, such a help as our "Standard Curriculum," for the harassed young superintendent or instructor to turn to for inspiration and very practical help. It represents the best that has been worked out in our schools, and is designed to give our young women in training a broad foundation for their future work at home or over-seas. It is the work of a splendid committee, of which our Miss Nutting is chairman, and which includes a group, each member of which is a leader in the nursing profession.

It is a democratic piece of work, because each outline, after being worked out by a member of the committee especially qualified in her particular subject, was sent to representative training school superintendents, teachers, supervisors, and public health nurses throughout the country for careful criticism and suggestions. These suggestions were then compiled, the outlines rewritten, and referred back to the different members before being finally approved. Where there was difference of opinion the majority opinion was accepted. It is the intention of the committee to revise the curriculum from time to time, and the assistance of all interested in the better training of nurses is asked to make this work of the utmost value in establishing and maintaining good standards of nursing education. It is hoped that the "Standard Curriculum" will be successful in interpreting to the general public a fair idea of what, under our present system, is conceived to be an acceptable training for the profession of nursing.

The general scheme of the book includes after the introduction:—

1. The Relation of Hospital and Training School Organization and Administration to the Curriculum. In this division such vital topics are considered as, "The General Purpose, Character and Standing of the Hospital; the Form and Functions of Training School Control; the Type and Capacity of the Hospital; Its Financial Resources; the Teaching Field (Range, Variety and Character of Services); Conditions of Life and Work for Students (Ratio of Nurses to Patients, Hours of Duty; Housing and Living Conditions, etc.); the Administrative

*The Standard Curriculum for Schools of Nursing was prepared by the Committee on Education of the National League of Nursing Education and published by the Waverly Press, Baltimore, Md.

and Teaching Staff; Standards of Entrance to Schools of Nursing; Standards and Methods of Good Teaching; Teaching Equipment; Records; University Affiliations; References on Nursing Education and Teaching." This section provides, as will be seen, much information which will enable the hospital superintendent, and trustees, as well as the training school committee, to see the needs of the school as such, and will be of use to them in measuring up the institution which the school serves, to see in what measure the existing services and general conditions should be improved to add to the strength of the course in nursing offered by their school.

2. The Course of Study includes (a) the General Scheme of Theoretical Instruction and (b) the General Scheme of Practical Instruction. Each subject is outlined (in the theoretical branches) giving the time allowed to the subject, the methods to be employed, and the objects of the course. Laboratory work is advised wherever possible, since no amount of book knowledge can be as valuable as facts which the student has seen demonstrated with material she has herself handled.

The value of the clinic is stressed for the same reason, and excursions are urged as a modification of the demonstration, where students visit places illustrating certain conditions which they wish to study. A group of junior pupils who last year had the privilege of spending two days each in visiting with the Henry Street nurses, will never forget the impressions received, either of the worthwhileness of the work of the visiting nurse, or the economic and social causes of so much of the sickness seen by them in the hospital wards.

The conference or case-study method is suggested for the older nurse, especially in such subjects as "Professional Problems," "Introduction to Public Health Nursing," etc. The study period is advised for immature pupils who need supervision, instruction in the method of

study, demonstrations in the use of reference material, taking of notes, etc.

The outlines for the science courses are extremely helpful because they include suggestions for the laboratory experiments in connection with the lecture and recitation. Methods of teaching, equipment and illustrative material, text and reference books are all discussed in detail.

Some of the newer subjects considered in the course of study are: "Housekeeping Problems of Industrial Families," "Public Sanitation," "Occupation Therapy," "Nursing in Mental and Nervous Diseases," "Nursing in Occupational, Skin and Venereal Diseases," "Emergency Nursing and First Aid," "Special Disease Problems."

Under "Social and Professional Subjects" are considered the "Historical, Ethical and Social Basis of Nursing," "Elements of Psychology," "Principals of Ethics," "Survey of the Nursing Field," "Professional Problems," "Modern Social Conditions."

"Special Branches of Nursing" include "An Introduction to Institutional Work," "Introduction to Private Nursing," "Introduction to Public Health Nursing and Social Service," "Laboratory Technic."

Public health nurses and social workers can no longer say that the training schools do not recognize the value of their work. Preventive measures are stressed throughout the curriculum, as are the underlying causes of disease, economic and social. Not alone in the subjects which deal most closely with these problems, but in every subject, the value of education and the need for social reform is emphasized.

The scheme of practical work is designed to give an all-round knowledge of nursing procedures, and elective periods are provided so that the pupil may develop her special aptitudes, in a way not possible in the limited period of the regular course.

No school is so small or so handicapped that it cannot



Copyright by Harris & Ewing.

NURSING COMMITTEE OF THE GENERAL MEDICAL BOARD OF THE COUNCIL OF NATIONAL DEFENSE, (AT RECENT CONFERENCE WITH COL. J. M. T. FINNEY IN WASHINGTON).

Lower row, left to right—Miss S. Lillian Clayton, Philadelphia, president National League for Nursing Education; Miss Annie W. Goodrich, inspector general of Nursing Service in United States and France and dean of the Army School of Nursing; Miss Mary Beard, Boston, president National Organization for Public Health Nursing; Miss M. Adelaide Nutting, chairman of committee, professor of nursing and health, Teachers' College, Columbia University, New York City; Mrs. John H. Higbee, superintendent Nurse Corps, United States Navy; Miss Dora L. Thompson, superintendent Nurse Corps, United States Army.

Second row, left to right—Miss Jane A. Delano, director Division of Nursing, American Red Cross; Miss Clara D. Noyes, president American Nurses' Association; Miss Ella Phillips Crandall, secretary of committee, executive secretary National Organization for Public Health Nursing; Miss Hannah J. Patterson, resident director woman's committee, Council of National Defense; Miss Pearl H. Braithwaite, assistant secretary of committee.

Third row, left to right—Col. John M. T. Finney, chief consultant in surgery, American Expeditionary Forces in France; Col. William H. Welch, Surgeon General's Office; Col. William J. Mayo, chairman Surgical Advisory Board, Surgeon General's Office; Brig.-Gen. Robert E. Noble, chief of Hospital Division, Surgeon General's Office; Lieut.-Col. Robert L. Dickinson, medical adviser, Operations Division, General Staff; Dr. Franklin Martin, member of advisory commission, Council of National Defense, and chairman of council's General Medical Board.

benefit by enriching its curriculum. One small hospital giving excellent surgical and obstetrical work to its nurses, has greatly improved its course by an affiliation with a contagious hospital, which teaches the most up-to-date aseptic nursing of patients suffering from communicable diseases. This school also sends its nurses out for a month each with the visiting nurse in the community. The nurses go out in the morning only, and make their first visit to each patient with the supervising nurse, yet in one month they average one hundred visits. A course in massage, given by a teacher from a nearby town, a class room, which had formerly been a dormitory for female help, a small demonstration room; these facilities, with additional graduate nurses, one to assist the many-dutied superintendent of nurses, one to train pupils in operating room technic, another to assume the responsibility of the hospital at night, all were found to be quite possible, even in a little institution much handicapped by lack of funds.

Another larger and more prosperous hospital had no space for laboratories for its nurses. An excellent technical high school in the community gave most cordial co-operation, arranged special classes in chemistry, biology and dietetics, at hours best suited to the needs of the hospital, and gave splendid instruction to probation and junior nurses, who attended the classes accompanied by an instructor, who coordinated this work with the instruction given in the hospital. Not the least valuable of the work given by the high school was a gymnasium course. This was compulsory to all probationers and permissible to others in the school.

Every community may be tapped for the training school with benefit to both sides. In the rural district, much might be done to interest the student nurse in the needs of the rural community. A course in school nursing could be given and valuable clinics held with school children, by cooperating with the school committee.

The visiting teacher should play an important part in the smaller school and the visiting teacher already finds the "Standard Curriculum" of value when she is trying to persuade the members of sceptical boards, of the value of introducing newer methods and equipment and of correlating their work with all like institutions in the vicinity, to enable them to train nurses properly for community service.

The nurse is a public servant with distinct responsibilities and opportunities. These are considered throughout the courses as outlined in the Curriculum, as is also considered the fact that the hospital must make an educational return to the students for the valuable practical nursing which is, after all, that upon which the hospital is so dependent for the adequate care of its patients.

* * * *

Students of the Vassar Training Camp Assigned to Duty

The intensive preparatory course given at the Training Camp at Vassar was completed September 13, and the students who have had the advantage of this special preparation will continue their course in training in the various hospitals listed below:—

Albany General	3
Barnes Memorial, St. Louis	14
Bellevue	59
Boston City	20
Brooklyn	18
Children's, Boston	4
City, New York	26
Cincinnati General	20
Connecticut Training School, New Haven	10
Garfield Memorial, Washington	1
Hartford	8
Hahnemann, New York	4

Johns Hopkins	3
John Sealy, Galveston	2
Lakeside	29
Lane, San Francisco	2
Massachusetts Homeopathic, Boston	3
Massachusetts General	7
Memorial, Richmond	6
Mountainside, Montclair	1
Methodist Episcopal, Brooklyn	7
Military	16
Mount Sinai, New York	37
Pasadena	1
Pennsylvania, Philadelphia	10
Philadelphia General	21
Presbyterian, New York	24
Presbyterian, Philadelphia	9
Post-Graduate	8
Rochester General	6
Roper, Charleston	1
St. Luke's, New York	5
St. Luke's, Chicago	2
University of Iowa	2
University of Michigan	13
University of Minnesota	1
Newton	11
Toledo	2

* * * *

ENROLLMENT OF RED CROSS NURSES

Official Statement From Red Cross Headquarters—Pacific Coast Leads in Percentage—Atlantic Division Leads in Actual Numbers

In actual number of nurses enrolled with the Red Cross since the United States entered war, the states of New York, New Jersey and Delaware led on August 1, according to a statement just issued from American Red Cross headquarters. These three states, the Atlantic Division of the Red Cross, have assigned to war duty 2,600 nurses, or 45 percent of their allotment of 5,708. To supply their full quota, these three states in the next four and a half months must enroll 3,108 additional graduates of recognized schools for nurses.

The total number of war nurses assigned by the Red Cross to war service, from the time the United States entered the war until August 1, was 13,347. The Red Cross is conducting intensive nurse recruiting campaigns throughout the United States to secure for Surgeon General Gorgas 8,000 additional nurses by October 1 and the remainder of the required 27,000 before the New Year.

Second in number of nurses supplied is the Central Division—Illinois, Michigan, Wisconsin, Iowa and Nebraska—from which 2,311 graduate nurses have enrolled. This is 58 percent of the quota of this division, which must secure 1,629 nurses before the end of the year, to meet its full allotment.

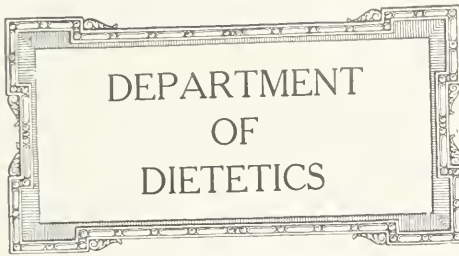
The New England Division states are third in number, with 1,360 nurses assigned, or 41 percent of their allotment, and 1,958 nurses still to be secured.

Pennsylvania and Delaware have secured 60 percent of their allotment, or 1,302 nurses. The Lake Division—Ohio, Indiana and Kentucky—has secured 43 percent of its nurses—1,205—and has yet 1,543 nurses to enroll.

In percentage of quota of nurses secured by August 1, the Pacific Division—California, Nevada and Arizona, leads with 899 nurses out of its quota of 1,036 nurses, or 87 percent of its allotment.

The Mountain Division, Wyoming, Utah, Colorado and New Mexico, is second, having supplied 83 percent of its quota, or 221 of the 264 nurses allotted to it.

The Southern Division, composed of Tennessee, the Carolinas, Georgia and Florida, on August 1 had supplied 382 out of 1,371 nurses called for by January 1, or 28 percent of its allotment.



Conducted by LULU GRAVES.

Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, in care of The Modern Hospital, 58 E. Washington St., Chicago.

American Dietetic Association

A most successful meeting, judged from the point of view both of attendance and of enthusiasm, was held by this association in conjunction with the section on dietetics of the American Hospital Association, at the Royal Palace Hotel, Atlantic City, September 26-28.

Since this was the first meeting of the Association, it was particularly gratifying to find so much interest manifested by the dietitians of the country.

The following officers were elected: President, Miss Lulu Graves, 58 East Washington St., Chicago; first vice-president, Miss Lenna Cooper, Battle Creek Sanitarium, Battle Creek, Mich.; second vice-president, Miss Violet Ryley, Military Hospital of Canada, Toronto, Canada; secretary, Miss E. M. Geraghty, New Haven Hospital, New Haven, Conn.; treasurer, Miss Emma Smedley, 1425 Brandwine St., Philadelphia.

A number of very opportune and valuable papers were read. A full report of the meeting of the American Dietetic Association will appear in November number of THE MODERN HOSPITAL.

* * * *

DIETARY STUDIES MADE IN THE MISSOURI STATE HOSPITALS FOR THE INSANE*

Investigation in Four Hospitals Shows the Necessity of Practical and Well-Trained Dietitians

By JUNE FINDLEY, M.A., Associate Professor of Home Economics, College of Industrial Arts, Denton, Texas.

The dietary investigations were made in the four Missouri State Hospitals for the insane, known as State Hospitals No. I, No. II, No. III, and No. IV. The series of investigations were started at the request of the superintendent of one of the hospitals for some member of the home economics department to visit his institution and to advise him as to the suitability and the cost of the dietaries which he was serving. With the cooperation of the secretary of the State Board of Charities of Missouri, Mr. Wagner, and the superintendents of the remaining three hospitals, arrangements were made to extend the visits to all of the state hospitals for the insane in the state. The studies were made in March, April, and May in the spring of 1917. The total number of persons considered in the study was 5,625; of that number 335 were employees in two of the institutions.

The food department in Hospitals No. I, No. II, and No. IV depended upon a matron to plan the dietaries and to see to the preparation and serving of the food. Hospital No. III was the only hospital at that time employing a trained dietitian.

The purpose of the investigation was to determine the adequacy of the dietaries which were being served and to find out if they were being planned as economically as possible. The data necessary to carry this out should enable one to determine: (1), the calorie requirement of the patients; (2), the amount of food served; (3), the extent to which the food selected was meeting the requirements of the patients; and (4), the cost of the food served.

CALORIE REQUIREMENT OF THE PATIENTS

With these groups of people it was felt that the main factors determining the calorie requirement of the patients were (1) the weights of the patients, and (2) the amount of work done.

AVERAGE WEIGHT OF PATIENTS

It was not practical to weigh every patient in the hospital, as some of them were bedridden, but between 75 per cent and 95 per cent of the total number of the patients were weighed in each hospital. The low percentage weighed occurred in only one hospital. The patients in the first two hospitals in which the investigations were made were weighed on physicians' scales, while those in the other two hospitals were taken out to the stock scales and weighed in groups of from twelve to sixty individuals. Either method used in weighing caused very little disturbance among the patients, although a few refused to be weighed. Many of the patients were anxious to be weighed, and several hobbled out to the scales when they had refused to go out of doors for many months before.

The weights of the individual patients varied greatly. For example, in a women's ward one patient weighed 350 pounds, while her companion weighed only 70 pounds. Table I shows the average results of the weighings made in each hospital.

TABLE I.—AVERAGE WEIGHTS OF PATIENTS IN THE HOSPITAL.

Institution.	Men.	Women.
Hospital No. I.....	141.2 pounds	125.8 pounds
Hospital No. II.....	141.6 pounds	115. pounds
Hospital No. III.....	143.3 pounds	131.8 pounds
Hospital No. IV.....	131. pounds	112. pounds
Average in all Hospitals.....	139.2 pounds	121. pounds

It is of special interest to note that the patients whose weights averaged the highest, both men and women, were in the only hospital employing a dietitian. The average weights would seem to indicate that the patients were needing a liberal amount of food.

AMOUNT OF WORK DONE.

The second factor used in obtaining the energy requirement of the patients, was the amount of work done. This was determined as accurately as the time given to the investigation allowed.

The patients were classed in two groups, the non-working and the working patients. Those classed as non-workers were the patients who were bedfast, semi-invalids and those who were able to walk about but performed no work at all, except a few, perhaps, who occasionally did a small amount of light work.

The patients classed as working patients did not do a uniform amount of work. A few of the patients worked hard and used considerable energy, working on the hospital farm, in the laundry, bakery, kitchen, and at various other occupations. The majority of the working patients assisted in serving the food, washed dishes, took care of the rooms occupied by the patients and performed other duties requiring a limited amount of energy. It was not

*Taken from thesis accepted for Master's Degree, University of Missouri.

¹Rose: Feeding the Family, pp. 47, 75.

possible to classify the patients according to wards, as they were classified according to the type of insanity with which they were afflicted. For example, in one of the epileptic wards in one of the hospitals two or three of the patients were among the best workers in the hospital when not having one of their disturbed periods, but the majority of those patients were not able to do much, if any, work.

CALCULATING THE ENERGY REQUIREMENT

In calculating the energy requirement it seemed that by classifying as working patients the patients who worked, even though they performed only a small amount of work in a number of cases, there would be no danger of calculating the energy requirement of the patients too low. If there should be an error in the calculations, it would be better to have the calorie requirement too high than too low, because the average weights of the patients were found to be below normal.

As far as can be found, the actual energy requirement of the insane has not been worked out, so it was necessary to figure the calorie requirement according to the amount needed by normal adults who were doing what was thought to be the same amount of work. The figures used were based on those given by Mrs. Rose in "Feeding the Family." It seemed that for the patients classed as non-workers 2,500 calories for the men and 2,000 calories for the women per person per day would be ample in amount. The men classed as working patients were calculated as needing 3,000 calories per man per day and the women, 2,500 calories per woman per day. With these figures the average calorie requirement of each patient in all of the hospitals was 2,533 calories. This average requirement is 33 calories more than Dr. Atwater³ considered necessary to meet the physiological demands of such patients when the number of men and women were half and half. In the Missouri hospitals the men outnumbered the women slightly.

THE AMOUNT OF FOOD SERVED

The next point considered was the calorie value of the food served. In general, the calorie value of the food was figured from the amount of the food materials the cook and the baker used on two successive days. This was felt to be a very fair average, since the data included the food used on a meat and meatless day, and aside from this difference the menus usually varied but very little. It seemed that very little food value was lost in the methods of preparation used, and it was impossible to weigh the food after it was prepared, except in the smallest hospital.

TABLE 2.—AVERAGE CALORIE REQUIREMENT OF PATIENTS AND CALORIE VALUE OF FOOD SERVED

	Hospital No. I	Hospital No. II	Hospital No. III	Hospital No. IV
Average number of calories served per person per day.....	3,227	3,074	3,175	2,868
Average number of calories required per person per day.....	2,542	2,431	2,546	2,614
Per cent of protein calories served.	12%	17%	10%	12%

According to the figures, the calories of food served more than met the calorie requirements of the patients and allowed a margin of from 15 to 20 per cent for waste. In investigations made in similar hospitals in New York and in the Government Hospital for the Insane in Washington, D. C., under the direction of Dr. Atwater,⁴ the waste of the food served to the patients was estimated to be from 25 to 30 per cent, respectively. This amount of waste, however, was considered unusually large and in-

cluded the plate waste and the food sent back to the kitchen which had not been served.

Table 2 also shows the average percentage of protein calories served. Hospital No. III served the lowest percentage of protein calories, but it was in the most available form. They depended largely upon milk, while several of the other hospitals depended largely upon legumes for protein.

SELECTION OF FOOD

The next point considered was the selection of the food. A copy of the menus served for one week in each hospital was obtained. In the average insane hospital it seems that the menus are repeated week after week, varying slightly with the season of the year. The following are sample menus collected when the study was made.

SAMPLE MENUS SERVED IN ONE OF THE HOSPITALS

BREAKFAST					
1st day	2nd day	3rd day	4th day	5th day	6th day
Fried liver	Oatmeal	Beef stew	Oatmeal	Bacon	Oatmeal
Bread	Bread	Bread	Bread	Gravy	Bread
Oleo	Oleo	Oleo	Oleo	Bread	Oleo
Sirup	Sirup	Sirup	Sirup	Sirup	Sirup
Coffee	Coffee	Coffee	Coffee	Coffee	Coffee
Milk*	Milk	Milk	Milk	Milk	Milk
DINNER					
Backbones	Beef roast	Pork and beans	Pork	Beef and dumplings	Pig's feet
Wiener-wursts	Gravy	Parasnis	Parasnis	Cornbread	Navy beans
Parasnis	Potatoes	Bread	Bread	Tea	Bread
Bread	Bread	Tea	Dressing	Milk	Tea
Tea	Tea	Milk	Milk	Rice pudding	Milk
Milk*	Milk				
SUPPER					
Hominy	Mush	Mush	Rice	Hominy	Mush
Bread	Bread	Bread	Bread	Bread	Bread
Oleo	Oleo	Oleo	Oleo	Oleo	Oleo
Sirup	Sirup	Sirup	Sirup	Sirup	Sirup
Dried apples	Dried peaches	Prunes	Prunes	Dried peaches	Prunes
	Cake			Milk	Milk

*Milk was served to the majority of patients for only cereal and tea or coffee.

SAMPLE DINNER MENUS SERVED IN ONE HOSPITAL

1st day	2nd day	3rd day	4th day	5th day	6th day
Lima beans	Roast beef	Navy beans	Pinta beans	Lima beans	Roast beef
Potatoes	Beans	Hominy	Hominy	Macaroni	Beans
Oleo	Bread	Bread	Bread	Oleo	Hominy
Coffee	Oleo	Oleo	Oleo	Coffee	Bread
Sirup	Coffee	Coffee	Coffee	Sirup	Coffee
	Sirup	Sirup	Sirup		Sirup

The sample menus given were the skeleton menus used for the hospital. Suitable changes were made for the different classes, namely, those which partially met the requirement of the working patients, tuberculous patients, those in the receiving wards, and those patients on special diets. The menus show that there was danger of depending too largely upon cereals and legumes for calories. The monotony of such diets is undesirable, but more important, of course, is the danger of using too much of these foods in the diet. McCollum⁵ has recently pointed out the danger of using too many beans for food. Forbes⁶ says that a high ash is valuable and that the mineral substances should preferably yield a basic ash on burning in the body. The amount of cereals used was large and the amount of milk and other base forming foods was low in a number of the diets.

Very little, and in several hospitals no, fresh fruit or vegetables or leaf vegetables were being used. Since this was true in several of the hospitals, it would seem that those hospitals were failing to supply some of the important food constituents which are not measured by calories. In Hospital No. III the dietitian was serving a generous amount of milk and fresh and leaf vegetables. Hospital No. I was also serving a very good amount of milk and some leaf vegetables.

⁵McCollum, Simonds and Pitz: The Dietary Deficiencies of the White Bean, Jour. Biol. Chem., April, 1917, p. 526.

⁶Forbes: The Mineral Nutrients, in Practical Human Dietetics, Jour. Home Econom., March, 1916, p. 129.

³Rose: Feeding the Family, pp. 55, 76.

⁴Atwater: Diets for Hospitals for the Insane, State of New York, State Comm. in Lunacy, Thirtieth Ann. Rep., p. 108.

⁵Atwater, W. O.: Diets in Relation to Hospitals for the Insane, Ann. Rep. of the Office of Experiment Stations for the year ended June 30, 1904, p. 478.

The food in general in the hospitals was well prepared, but a lack of variety was shown in the food materials used and in the method of preparation in those hospitals not employing a dietitian.

THE COST OF THE FOOD

In considering the cost of the food it was found that the cost of the food materials used averaged 0.138 cents to 0.257 cents per person per day. A number of factors influenced the cost, but it seemed that the hospitals were paying the minimum amount possible for their food, and in several instances not enough to give the patients the food they needed. The hospital paying the highest amount was the one serving the most adequate food. The dietitian had saved the superintendent of this hospital so much loss from waste that he was able to spend this amount for food and did not feel that the food used was costing more than it had before the dietitian was secured.

CONCLUSION

The investigation showed there was need for great improvement in the three hospitals and that important food substances were being sacrificed, probably owing to the high price of food, and it demonstrated the necessity of having the food department controlled by a capable and well-trained dietitian.

But the dietitian can not work alone; she must have the cooperation of the one in charge of the institution, and those contributing to its financial support, as well as that of all employees working with the food department.

THE DIETITIANS' QUESTION BOX

Gluten Flour for Diabetics

To the Editor of the Department of Dietetics:

Will you give me the name of a reliable brand of gluten flour which would be safe for diabetic patients?

A PHYSICIAN IN PRIVATE PRACTICE.

The gluten flours on the market are not safe for diabetic patients to use in unlimited quantities. The safest way to use any flour or bread substitute for diabetics is to choose either a gluten flour or bran with a known percentage of starch and use it in restricted amounts, according to the condition of the patient. Many gluten flours and brans are put in packages with the analysis printed on the package or on an enclosed folder. Manufacturers of gluten flours do not claim for them that they are free from starch, but put emphasis upon the high percentage of protein they contain. Since we know that sugar can be formed from protein in the diet, we restrict the quantity of this as well as of carbohydrate. Breads for diabetics are given as a means for serving butter, cheese, peanut butter, etc., rather than for their high food value. A very good muffin for diabetics may be made from equal parts of bran and soy bean flour, the patient being given one muffin daily, one each meal, or any number which the physician decides is advisable.

The Food Value of Gelatin

To the Editor of the Department of Dietetics:

Has gelatin a high food value?

A DIETITIAN IN A SMALL HOSPITAL.

From the point of view of nutrition, gelatin is not of great value. It cannot satisfy the protein requirement of the body because it is lacking in amino acids and some other forms of protein. While our tables on food composition rate gelatin as being about seven-eighth protein—that is, 34 grams of gelatin contain 31 grams of protein,

as we use it, this percentage is very much too high. An ounce of gelatin will coagulate one quart of liquid; this amount will make a dozen servings, making a very small amount of gelatin in each serving.

The food value of gelatin is more than the nutritive value, however, as it furnishes a good medium for serving cream, fruit juices, wine, and other things which are nourishing or stimulating, and thereby giving variety to a restricted diet. It may serve as a means of utilizing small amounts of fruit, vegetables or meat which would not be acceptable, or sufficient in quantity, if used alone. Gelatin dishes can be made very attractive, and that is also a feature which is valuable in a food.

A Nurses' Course in Dietetics

To the Editor of the Department of Dietetics:

I should be very grateful if you would suggest an outline for a course of lessons in dietetics for nurses.

A SUPERINTENDENT OF A TRAINING SCHOOL.

This question is asked so frequently that one is made to feel it a problem in a large number of hospitals. Conditions differ so greatly that a course in dietetics which may be applicable to different hospitals can scarcely be outlined. A few general principles, however, may always be followed. Soon after entering school the nurse should be taught how to care for milk and such other food materials as are kept in the supply cupboard of the ward; how to prepare toast, eggs, and the various hot and cold drinks—in fact, anything which is prepared in the ward serving room—and how to serve a tray properly and expeditiously. This can be done in three to five lessons.

In a later course the food value of all common food materials should be given, including composition, digestion and absorption, the effect of cooking upon food value and digestion, and the application of these principles to dietetic treatment of disease. This may be given in twelve lessons, but it would be much more desirable to have eighteen or twenty.

As no textbook covering the various phases of the subject is available, it is better to have more than one author for reference; for instance, one giving a thorough study of food materials, one on diet in disease, and one on nutritional physiology. This affords an opportunity for the nurse to get from reading information which she could not obtain in the short period in the class room. The more she learns of this subject, the more she realizes its value. Our medical men frequently complain of the lack of care given to the special diets; until nurses are taught that the diet of these patients should be given the same thought and attention as is given to the medication of medical patients there will still be cause for complaint. Emphasis should be placed upon the practical points, and their place in dietotherapy.

NEWS NOTES OF DIETITIANS

Miss Anne Upham, formerly assistant dietitian at Lakeside Hospital, Cleveland, Ohio, is with Base Hospital No. 9, B. E. F., France. Her work has been so satisfactory that she has been given a very decided promotion, and her department is being pointed out as an example to other base hospitals in the B. E. F. Recently Miss Upham was asked to write an outline of her work and methods, that copies of it might be distributed in the other hospitals. A part of this report is as follows:

"The work of the dietitian at No. 9 General Hospital is not only concerned with the special diets but with the

diets of all patients in the hospital. There is no diet kitchen for special diets only. Supplies are very limited and it seems best to work in close cooperation with the main kitchen. For example: The heaviest part of the special diet work comes at noon, when the dinner trays are brought in. Bowls or small mess tins are placed on the tray, so that it is taken to the wards with the ward dinners, thus doing away with a special trip to the diet kitchen. In the medical wards, the special diets consist chiefly of diets for nephritis, gastritis, gastric ulcers, chest wounds, and also for patients who, owing to a loss of appetite, refuse to eat the ordinary diet. The special diets for the surgical wards are liquids for operative or other patients, for whom broth and milk soups and custards are provided; patients with jaw and face wounds, for whom soft food, such as mashed potato, milk toast, minced meat, etc., is provided; and extra nourishments for patients whose resistance is low. These extra diets include any nourishing food which can be obtained, such as extra custard, bread pudding made from scraps of bread, extra vegetables, soups, etc.

"The dietitian has control of the preparation and serving of the food for all the patients, both in the wards and in the dining hall. There must be a close cooperation between the quartermaster, the steward, and the dietitian, as well as between the dietitian and mess sergeant. It is necessary that the dietitian know the ration allowed by the British Government per patient, and then make sure that she gets all that is due for the number of patients in the hospital at that time. She also should know what is brought in each day from the supply depot. The food arrives at the hospital about noon. By afternoon the dietitian should know what is in the store, prepare the menus for the following day, and arrange the work as to food, fires, boilers, etc., to the best advantage.

"The dietitian supervises the preparation of all foods, making sure that the food is properly cooked and seasoned before leaving the kitchen. She also has charge of the serving of food into the trays for the wards, seeing to it that each ward has enough, but not too much, food for the number of patients.

"Another important work carried out by the dietitian is the work on the wards. She visits as many wards as possible during meal times in order to control the amounts of food used and to stop all waste. Regarding special diets, the dietitian keeps in close contact with the medical officers and sister (and patient if necessary).

"There is one more large problem which rests upon the dietitian, and that is the serving of the patients in the dining hall. The greatest difficulty there is to keep the food hot and to see that each man gets enough food, but not so much that some will be left on the plates or tables. The bread is one item that has to be very closely watched.

"In brief, the duties of the dietitian in this base hospital are: (1) to supervise special diets (which includes sick officers' diets); (2) to supervise the selecting (wherever there is any choice), preparing and serving of food to the patients, in the kitchen, wards, and dining hall; (3) to bring in closer union the serving of the meals in the wards and the preparation of food in the patients' kitchen. For example: Two wards may have the same number of patients; however, if they were given the same amount of food, Ward A would have food left over, while Ward B would not have enough to serve all its patients. A more satisfactory division may be obtained if one person remains in the kitchen when meals are being apportioned and one visits the wards when meals are being served to the patients.

2,500-BED UNITED STATES ARMY GENERAL HOSPITAL TO BE BUILT IN 100 DAYS

First Permanent Army Reconstruction Hospital to Be Built at Chicago—Largest and Most Completely Equipped in Country—Twenty-eight Buildings, Main Hospital Building 2,040 Feet Long—Land, Buildings, and Equipment to Cost \$4,500,000

Considerable interest attaches to the Army General Reconstruction Hospital to be built at Speedway Park, Maywood, Illinois (a suburb of Chicago) in that it is the first reconstruction hospital, of permanent construction, to be built by the War Department since the declaration of war. The land, main buildings, administration, receiving, kitchen, laundry, power, and seven storage houses will cost \$2,500,000,000, while the equipment will cost an additional \$1,000,000.

The plans were prepared by Richard E. Schmidt, Garden and Martin, and construction has been started. The main hospital building is to be completed within one hundred working days, and it is expected that it will be available for hospital purposes late in December.

The buildings already planned will occupy twenty-five acres, although 312 acres were purchased to allow ample room for such expansion as may ultimately be found necessary. The hospital will be known as the United States Army General Hospital and will be designated by a number. The plans call for one main hospital building and twenty-seven auxiliary buildings, to be equipped with the most modern appliances obtainable. The hospital proper and the administration building will be of reinforced concrete fireproof construction; the hospital building to be fifty feet wide by 2,040 feet long, and four stories. It will have a capacity of 2,500 beds, it being planned to care for 50 per cent of the patients in wards of one hundred beds each and the remainder in smaller wards and single-bed rooms. Each floor will contain eight sections, with complete auxiliaries of kitchens, baths, quiet rooms, utility rooms, laboratories and treatment rooms. A solarium and open-air balconies will be provided for each section.

In addition to the main hospital building, an administration building and power house will be constructed of reinforced concrete, while the kitchen, laundry, machine shop, laboratory, seven storage houses, chapel and receiving station will be of mill construction with stucco exterior.

One hundred doctors, 250 nurses, and 750 enlisted men will be necessary to care for the patients. The nurses will be housed in a group of five buildings, to be erected just east of the main buildings; five more buildings will be given over to the enlisted hospital corps detachment, and the officers and doctors will be housed in two additional buildings.

MEETING OF AMERICAN PUBLIC HEALTH ASSOCIATION

A convention of United States and Canadian sanitarians will be held, under the Auspices of the American Public Health Association, at Chicago, October 14-17. Among the prominent military sanitarians who will address the meetings are Surgeon-General Gorgas, Col. Victor C. Vaughan, and Maj. William H. Welch, of the Army Medical Corps. The speakers at the general sessions will include George H. Vincent, president of the Rockefeller Foundation, Dr. Charles J. Hastings, president of the American Public Health Association, Dr. W. A. Evans, Assistant Surgeon General Allan J. McLaughlin, U. S. P. H. S., Dr. Ernest S. Bishop, Dr. Lee K. Frankel, and Dr. Frederick L. Hoffman.



Group of delegates, members, and guests attending the Twentieth Annual Conven

AMERICAN HOSPITAL ASSOCIATION MEETING, ATLANTIC CITY

Twentieth Annual Convention Deals With Vital Issues and War Program of Hospitals—Patriotism the Keynote—Report of Work Accomplished and Some of the Papers Read—Names of Those Present

The twentieth annual convention of the American Hospital Association closed Friday evening, September 28, after a four-day session at the Royal Palace Hotel, Atlantic City, N. J.

Unquestionably, this year's meeting will go down in the annals of the association as one of the most important ever held. The attendance was large—in fact larger than was expected because of existing conditions, and the interest at the general sessions, as well as in section meetings, was most keen. Atlantic City is at all times a most delightful convention city and because of its proximity to Washington, the center of all national activity at the present time, its choice as a meeting place this year was a most happy one.

As was to be expected, the entire meeting had a distinctly war atmosphere. Practically every part of the proceedings dealt with the war program of hospitals and their relation to the government. If there had been any doubt in the mind of any one as to where the hospitals of this country stood in relation to the present crisis, their patriotic attitude as manifested throughout this convention would surely have dispelled such doubts.

Whereas, the meeting at Cleveland last year was devoted more to discussions and plans for the future war program of the hospitals, this year's meeting showed definite progress and offered instructive discussions of the many problems now confronting hospital administrators.

A noteworthy feature of the week was the first annual convention of the American Dietetic Association, held in conjunction with the Section on Dietetics of the American Hospital Association, which proved a most interesting and valuable part of the meeting. This association has a most important field and the interest shown at its initial session promises valuable results for the future.

The 1918 convention was featured by a larger commercial exhibit than ever shown at a previous meeting. Hospital superintendents were quick to avail themselves of the opportunity to examine the wide range of merchandise shown and to discuss with the commercial representatives their requirements and problems. The majority of the exhibitors report a very satisfactory business, as a result. The success of this year's exhibit assures an even greater showing next year and the Commercial Section promises to become the annual market place of the hospital field.

It was decided that the next meeting of the American Hospital Association would be held in Cincinnati, Ohio. The exact dates were undecided, it being planned, however, to convene some time between September 15 and October 15, subject to the approval of the Board of Trustees.

GENERAL SESSIONS

OPENING SESSION, TUESDAY MORNING, SEPTEMBER 24

The keynote of the Twentieth Annual Meeting of the American Hospital Association was *Patriotism*. This note was struck in the official program with its decorations in national colors and its portraits of the President and Secretary of War; in the decorations of the Assembly Room of the Royal Palace Hotel; in the invocation delivered by the Rev. Thomas J. Cross of Atlantic City, who wore his chaplain's uniform; in the address by the mayor of Atlantic City, who, in the absence of Governor Edge, delivered the address of welcome; by the call of the president of the association for comprehensive and cooperative action on the part of hospitals in meeting the present needs of the war; and by the resolution offered by the secretary, declaring the purpose of the



ion of the American Hospital Association, Atlantic City, September 24-28, 1918.

association to support the President of the United States in the prosecution of the war.

Dr. Ancker's presidential address, which is given in full on another page, set forth the important issues to be considered by the American Hospital Association at this meeting.

The report of the special committee on institutional membership in the association, of which Dr. A. R. Warner of Cleveland was chairman, had been previously printed in full in *THE MODERN HOSPITAL* and reprints had been distributed before the meeting. Dr. Warner, therefore, considered it superfluous to read the report and called instead for a discussion in order that the debatable points might be thoroughly covered before any modification of the constitution recommended by the committee should come before the association for action on Thursday.

Mr. Richard P. Borden, a member of the committee, remarked that the future of the association depends largely on its financial basis. In order that its finances may be placed on a sound footing it must have the support not only of executive heads of institutions but of the hospitals themselves.

A point which aroused considerable interest was the committee's statement of its hope "that this change in the American Hospital Association shall be the first step in the standardization and classification of hospitals by this association."

The question of the principles and methods of this hoped-for standardization was raised. Dr. Warner replied that the details of this standardization remained to be worked out in the future. In reply to a question as to the relation between standardization by the American Hospital Association and standardization by the American College of Surgeons, Dr. Warner replied that there was at present no more relation between the work of these two organizations than there would be between standardization attempted by an association of internists or pediatricists or ophthalmologists or orthopedists. Any of these groups have the right to standardize hospitals according to their own ideas.

Mr. John G. Bowman, director of the American College of Surgeons, said that he wished that a better name

could be found for this work than "standardization," since this implied enforced similarity. Standardization he defined as a cross section of the condition of the hospitals of the country, showing the lines where progress can be made. This work, he said, must include the hearty support of doctors, hospital superintendents, trustees, laboratory workers and nurses. It requires the cooperation of all concerned in the hospitals, including the public. The American College of Surgeons has taken the initiative in this work and has spent much money and effort on it. The college asks the cooperation of hospitals only in so far as the hospitals themselves believe its program is right.

The question was raised as to the relation which would exist under the amended constitution between the various state hospital associations and the American Hospital Association. Dr. Warner replied that it was expected that a relation would be worked out similar to that which exists between the constituent state medical associations and the American Medical Association. This, however, remains to be determined.

Other questions raised were the meaning of "other organizations eligible to membership" and the advantage to an institution of possessing institutional membership in addition to the personal membership of its superintendent. In reply to the first question, Dr. Warner defined "other organizations eligible to membership" as institutions which had as their object the promotion of public health, and which, contributing to public health, though not hospitals, had interests closely related to those of hospitals. In reply to the second question, Dr. Warner said that, while it had not been deemed advisable to bring any pressure to bear on hospitals to induce them to take out institutional membership, it was believed that the advantages of being an insider rather than an outsider would manifest themselves as time went on. In reply to the question as to the relative voting power possessed by individual and institutional members, Dr. Warner said that it had been thought best not to deprive active personal members of the voting privilege. It was thought that an equitable adjustment had been reached in leaving active personal members in possession of one vote each and in

granting to institutional members the right of representation by three voting delegates each and as many other delegates with the privileges of the floor, but no vote, as might be desired. Dr. Warner called attention also to the machinery which had been devised for making the association more effective, namely an executive secretary with permanent office and a board of trustees, which is in effect an executive committee.

REPORT OF THE EXECUTIVE SECRETARY OF THE AMERICAN HOSPITAL ASSOCIATION

The report of the executive secretary, including membership and publicity committee report, follows:

The present Secretary of the American Hospital Association has acted in that capacity only since June 13, 1918. All of his efforts have been devoted to carrying out the plans for this Twentieth Annual Convention. On this phase of the work no detailed report seems necessary at this time.

As chairman of the membership committee, the secretary is expected to report for that committee. It seems necessary only to make the following statistical report which has been approved by the other members of the committee.

The membership to date shows the following members in good standing:

Active	940
Associate	284
Honorary	15
Life	9
	1,248

The following are the delinquents:

Active	151
	59
	210

Resignations:

Active	24
Associate	1

There have been three deaths during the past year. The office now has the cards of 52 members showing no addresses.

From September 1, 1917, to September 1, 1918, 115 new members have been accepted.

Approved by the Membership Committee:

HOWELL WRIGHT,
SISTER GENEVIEVE,
DR. A. W. SMITH.

The secretary has also been acting as chairman of the publication committee. There seems to be very little to report, however, except that the plans for the publication of the proceedings of the last convention, as set forth by the publication committee, have been carried out. The proceedings have been published and distributed. The committee believes, however, that in the future more economical arrangements can be made for the printing of the proceedings of each convention and recommends that careful consideration be given to any proposals that may be made.

Approved by the Publicity Committee:

HOWELL WRIGHT,
DR. H. K. MOHLER,
H. E. WEBSTER.

The secretary desires to emphasize to the members of the convention that no committee has a more important duty this year than the Time and Place Committee, which is to select the place for the next convention. Invitations have been received from a number of cities. They are now in the possession of the secretary, who has been in correspondence with convention boards and hotels in these various cities, for the purpose of obtaining information which may be used

by the Time and Place Committee to base its recommendation for the next convention city.

This association spends considerable money at each convention. Its members and guests spend more. Each year numerous invitations are received from various cities for the next year's convention. This is because it is a profitable convention for any city to entertain. The association, therefore, has a right to expect much in return for holding its convention in a given city. It is in a position to demand that all arrangements be on the basis of a business contract. The association should pay nothing for convention halls, commercial exhibit space, or for any purely local matter. In a word, other things being equal, this association should meet in the city which can make the best general proposition.

The secretary recommends that the association direct that all data now in his hands relative to convention cities be placed in the hands

of the Time and Place Committee and that the committee be instructed to go over this data carefully with the secretary before making its report to the convention.

Respectfully submitted,

HOWELL WRIGHT,
Executive Secretary.

The executive secretary, Mr. Howell Wright, before presenting his report, offered the following resolution, which was enthusiastically and unanimously adopted:

"Be It Resolved, That the American Hospital Association now assembled in its Twentieth Annual Convention, at Atlantic City, pledge its unswerving loyalty to the President of the United States and tender to him its fullest support and cooperation toward the successful conclusion of the Great War in which the Nation is engaged and the adoption of the fundamental principles of humanity advanced by him for the world."

The following message was received from the White House, September 25, in answer to this resolution:

My Dear Sir:

"The President has asked me to acknowledge the receipt of your telegram of September 24 and to thank you and those who joined with you for your generous expressions of loyalty and support.

Sincerely yours,
(Signed) J. P. TUMULTY,
Secretary to the President."

The executive secretary then announced the following appointments:

Committee on Time and Place—Mr. Pliny O. Clark, superintendent Ohio Valley General Hospital, Wheeling, W. Va., chairman; Mr. F. S. Bunn, superintendent Youngstown City Hospital, Youngstown, Ohio; Mr. Asa Bacon, superintendent Presbyterian Hospital, Chicago.

As Mr. Cornelius S. Loder of New York was the only member of the committee on accounting present, the following additional members were appointed to that committee: Mr. Francis Oliver Bates, superintendent Roper Hospital, Charlotte, S. C.; Mr. S. J. Barnes, financial secretary Orange Hospital, Orange, N. J.; Miss Rosa Saffair, superintendent Jamaica Hospital, Jamaica, New York.

OFFICERS OF THE AMERICAN HOSPITAL ASSOCIATION FOR 1918-1919

PRESIDENT.

DR. A. R. WARNER,
Superintendent Lakeside Hospital,
Cleveland, Ohio.

FIRST VICE-PRESIDENT.

DR. J. B. HOWLAND,
Assistant Administrator
Massachusetts General Hospital,
Boston, Mass.

SECOND VICE-PRESIDENT.

MR. A. B. TIPPING,
Superintendent Touro Infirmary,
New Orleans, La.

THIRD VICE-PRESIDENT.

SISTER IRMENA,
President Missouri Catholic Hospital Association,
St. Louis, Mo.

SECRETARY.

MR. HOWELL WRIGHT,
Cleveland, Ohio.

TREASURER.

MR. ASA BACON,
Superintendent Presbyterian Hospital,
Chicago, Ill.

TRUSTEE

DR. ROBERT WILSON,
Superintendent Willard Parker Hospital,
New York City

TRUSTEE

MISS MARY L. KEITH,
Superintendent Rochester General Hospital,
Rochester, N. Y.

TRUSTEE

MR. RICHARD P. BORDEN,
Fall River, Mass.

WAR SERVICE PROGRAM—WEDNESDAY, SEPTEMBER 25
HOSPITALS AND MEDICAL ATTENTION—MORNING

Before Mr. Borden read the report of the war service committee, the president appointed a special committee of nine, to draft and present important resolutions, consisting of the following members: Mr. Richard P. Borden, chairman, Mr. Fred S. Bunn, Dr. J. M. Peters, Mr. Michael M. Davis, Miss Mary M. Riddle, Mr. A. B. Tipping, Miss Maude Landis, Mr. R. G. Brodrick, and Mr. Howell Wright, secretary.

The secretary also read the following communication from Mr. Benedict Crowell, acting secretary of war:

WAR DEPARTMENT
WASHINGTON

September 12, 1918.

To the Officers and Members of the American Hospital Association:

It was with deep regret that the Secretary of War was obliged to decline the invitation to attend the convention of your association on account of projected absence from the United States, for he would have welcomed the opportunity to meet with you and to address you concerning some of the problems which are of vital interest to both the War Department and the civil hospitals.

Mr. Baker fully appreciates the difficulties already encountered and foreseen by the civil hospitals and is deeply grateful for the splendid response and cooperation which has met our every demand thus far. He realizes that the demands of the War Department have in various ways seriously affected the administration of civil hospitals by the withdrawal of staff physicians, interns, nurses and employees.

An effort has been made to leave a sufficient number of physicians for the hospitals to enable them to operate satisfactorily, but this has been rendered difficult because of the patriotic spirit which has prompted many to go in spite of the representations made to them that their duty was to remain at home. But I need not enumerate the difficulties which you encounter, for you know them full well. I am sure that what you wish to know is the attitude of the War Department as to future protection.

As to physicians, we are aware of their need in civil as well as military establishments and attention will be given to the fullest possible extent to such measures as may be necessary to safeguard the civil hospitals in this respect.

As to the nurses—the army needs an enormous number, probably at least 50,000, by next July. While the majority of the graduate nurses come from other sources than the hospitals, still I am sure these institutions are affected to some extent. We have heard much about the danger of withdrawing so many graduate nurses, but I ask you to remember that up to this time (the middle of September) we have withdrawn for military service only about 16,000 nurses and that during the same time approximately 25,000 nurses have graduated from training schools. The subject of how to obtain the requisite number of nurses has been discussed and numerous plans have been suggested and some insistently urged. After care-

ful consideration, Secretary Baker has approved a program which has seemed to him to be the most sound and constructive of any under consideration, namely, the plan to supplement the supply of graduate nurses with pupils of the Army School of Nursing, which he has authorized, and which the Surgeon General is now putting into effect. In addition to this, hospital assistants will be used in the convalescent hospitals in this country. The details of these plans will, I am sure, be made clear to you by representatives of the Surgeon General. These plans are believed to be sound and to be the most satisfactory, both from the standpoint of the army and as a safeguard to

the civil training school for nurses. Time will demonstrate the supplementary measures to be taken if and when necessary. The success of these plans will depend to a large extent on your support and avoidance of all that tends to confuse the issue. I count upon and urge your cooperation.

As for the other matter, which I know to be a real embarrassment—the shortage of employees—I wish to assure you of the interest and desire of the military authorities to assist in mitigating the difficulty so far as possible. To this end,

we would welcome suggestions from your association, for we are aware of the important role which the civil hospitals play in safeguarding the health of the nation and in maintaining the morale of the great public at home while our armies are fighting so nobly abroad.

In conclusion, I wish you to bear in mind that our program of five million men under arms by this time next year, necessitating approximately 500,000 hospital beds abroad and 200,000 hospital beds in the United States for army purposes, is a project of considerable magnitude. Its importance will readily show the need which we have of the loyal support and cooperation of all interests concerned.

In behalf of the Secretary of War, as well as for myself, I wish for your association a most successful and profitable meeting.

B. CROWELL, Acting Secretary of War.

Mr. Richard P. Borden, secretary of the war service committee, presented a report of unusual interest which elicited prolonged applause. Before reading the report proper, Mr. Borden displayed a series of charts showing the method by which the authorities at Washington sought to arrive at the proper location of the hospitals to be used for the returned soldiers, on the basis of centers of population and industry, railroad facilities and medical and hospital facilities.

In the course of the report, the war service committee summarized the principles for which it stood in all of its relations with the war department. The committee contends, first, that so far as possible, existing hospitals should be used for military purposes as a measure of necessary conservation of material and personnel; second, that the hospitals for the treatment of the returned soldiers should be located in centers of population; third, that the physicians at home should be used in these hospitals on part time military service; fourth, that a group

WHAT THE ATLANTIC CITY CONVENTION ACCOMPLISHED

Showed that the hospitals of the country are a real and indispensable factor in war service work.

Adopted a new constitution providing for institutional membership.

Illustrated the value of meetings at which hospital superintendents can discuss their problems.

Successfully presented the largest commercial exhibit ever shown by the association.

Demonstrated the ability of hospital people to think and plan constructively.

of volunteer hospital assistants should be created and trained for service in the home hospitals, both civil and military.

Mr. Borden's report was followed by a paper by Colonel Winford H. Smith, representing the Surgeon-General of the Army, on "The Problems of Medical Education and the Supply of Medical Interns and Medical Hospitals," which is presented in full following this report.

In the discussion which followed Colonel Smith's report, Mr. F. S. Bunn, of Youngstown, Ohio, emphasized the point that a wise solution of the general problem could be arrived at only by considering the civil and army needs as one problem. This involved, among other things, the health of the immediate members of the families of the soldiers sent abroad and the health of the industrial worker at home who was backing the soldier in the field abroad.

Mayor Hayward, of Toronto General Hospital, who has had both civil and military hospital

which the Vancouver General Hospital is meeting the medical needs of civil and military patients. (This is described by the superintendent of Vancouver General Hospital, Dr. M. T. McEachern, in one of the leading articles in this issue.)

Dr. Goldwater said that there was no logical contradiction between the position of the war service committee and that of the Surgeon General's Office. Already the services of the civil hospitals had been used for educational purposes and for the care of soldiers, and further exigencies would undoubtedly demand that further use be made of them. He said that he realized how perfectly natural it was that the Surgeon General's Office, faced with the stupendous problem of providing seven hundred thousand beds for the use of the army, should seek the line of least resistance, but he felt that if the military had looked with a more friendly eye upon the suggestions of the war service committee, an adequate organization could have been worked out for a wider use



OFFICERS
AMERICAN
HOSPITAL
ASSOCIATION.

1918-1919

PRESIDENT.

DR. A. R. WARNER,
Lakeside Hospital,
Cleveland, Ohio

SECRETARY.

MR. HOWELL
WRIGHT,
Cleveland, Ohio

TREASURER.

MR. ASA BACON,
Presbyterian
Hospital,
Chicago



experience, argued that the treatment of the soldier in civil hospitals was inadvisable because of the dual control involved and the attitude of the returned soldier toward the civil doctor who had not seen service abroad.

Mr. Borden sought to correct an erroneous impression which he felt existed in the minds of some, relating to the position of the war service committee. He stated that the committee never advocated the treatment of soldiers in civil hospitals under civil control. The committee did, however, contend that by a wise use of civil hospital space and facilities not now worked to their capacity, both material and personnel could be saved without in any way interfering with full military control and discipline.

An interesting account was presented of the way in

of existing civil hospital facilities. A suggestion which Dr. Goldwater made, which met with immediate response, was that in communities where for various reasons the number of patients in hospitals had diminished, a consolidation should be effected, whereby one or more hospitals could be completely turned over to the army.

Because of the amazing power of the local draft boards, which could not be adequately supervised because of their very large number and wide distribution, Dr. Goldwater felt that the convention should formulate very definite principles for the guidance of these boards in their consideration of the exemption and nonexemption of the personnel of hospital staffs.

In answer to a question regarding the attitude of the

War Department toward the resident staff, Colonel Smith could give no very definite reply, except to say that individual instances would have to be decided by local boards. He felt that visiting staffs would have to give more training to interns and that physicians physically unfit for army service could fill resident positions.



DR. ROBERT WILSON,
Trustee,

Willard Parker Hospital, New York City

Dr. A. R. Warner, of Lakeside Hospital, Cleveland, inquired whether the Surgeon General's Office had formulated any plan under which the physician or surgeon who refrained from enlisting to remain at his post at home could with dignity face his returned fellow medical officers after the war. Colonel Smith replied that the educational committee of the War Department was planning to do something about this as far as members of the teaching staffs were concerned, but this did not meet the situation of the rank and file of hospitals. An alternative proposition which had been considered was the drafting of the entire medical profession, each district being then asked to furnish its quota of men, a system which now prevails essentially in England. Thus far, however, no definite plan had been placed in operation.

During the course of the session the following resolution by Dr. Goldwater was unanimously adopted:

Resolved, That the American Hospital Association hereby express to the Secretary of War, the General Staff, and the Surgeon General of the United States Army, its grateful appreciation of the opportunity that has been given to its representatives during the past year to consult with the government in promoting the adoption of a medical program adequate to the needs of the country during the war; and

Resolved, That the association hopes and trusts that the cordial relations already established may continue, to the end that the welfare both of the military and civil population may be conserved and promoted."

RECONSTRUCTION AND REHABILITATION

The secretary called attention to the fact that for the first time in the history of the association the president

had invited the states to appoint official delegates and that thirty states had responded; also that the letter of the president to boards of trustees, urging that hospitals send official delegates to the annual meeting and pay the expenses of these delegates, had proved well worth while and such a measure would be found most useful for the future.

Dr. O. F. Ball, president of the Modern Hospital Publishing Company, presented the following resolution:

Be it Resolved, That we, the members of the American Hospital Association, gratefully acknowledge the message of good will extended to us by the Catholic Hospital Association at its recent annual convention; that we congratulate the association on its expressed action looking toward hospital advancement and a broadening of institutional service to the sick; and that we heartily desire that the bonds of our common aims hold the associations in close cooperation.

The resolution was unanimously adopted.

Mr. C. A. Prosser, director of the Federal Board for Vocational Education, Washington, D. C., who was to have read a paper on "The Federal Vocational Board and the Civil Hospitals," was unable to be present, and his paper was not read. Mr. T. B. Kidner, vocational secretary of the Invalid Soldiers' Commission of Canada, who has been lent by that commission to the Federal Board for Vocational Education, spoke briefly on behalf of Mr. Prosser before reading his own paper.

Mr. Kidner said that it had been found not enough to give the disabled man a medal, a pension, a "God bless you



MISS MARY L. KEITH,
Trustee,

Superintendent Rochester General Hospital, Rochester, N. Y.

—get out." The new idea was to make the man better morally and socially because of his experience and to rehabilitate him so that he could take his place as a self-sustaining and self-respecting member of society. For this not only medical treatment of the old kind but also occupational therapy had been found necessary. The

Federal Board for Vocational Education had been instructed by the government to cooperate with the Federal Department of Labor. In one respect the measures for vocational reeducation adopted by the Federal government are ahead of those of any other country. In other countries the disabled man who cannot return to his form-



COL. WINFORD H. SMITH.

Representing the Surgeon-General's Office at the Atlantic City Convention

er occupation receives free vocational reeducation and maintenance during the period of his training. The United States will give free vocational training not only to the man who cannot return to his former occupation but also to the man who is capable of resuming his previous work. He will not, however, receive maintenance during the period of training.

Mr. Kidner then read his own paper on "Canada's Rehabilitation and Reconstruction Work," which will be published in full in a later issue of THE MODERN HOSPITAL. Mr. Kidner's paper was followed by motion pictures showing the reeducational work done in Canada. Incidentally, Mr. Kidner remarked that it had been feared that after his life in the open a soldier would not readily return to vocations which took him away from the land. This, he said, was a mistake. He quoted one soldier who said, "I have had enough of the land. It has been in me boots, me hair, and me grub. Me for the steam heat and the white lights." Mr. Kidner also called attention to the fact that the Bankhead bill, now before Congress with good chances of passing, provides for the reeducation of the industrially crippled somewhat on the same lines as the Smith-Hughes bill provides for the reeducation of the war crippled.

Mr. Douglas C. McMurtrie, director of the Red Cross Institute for Crippled and Disabled Men, New York City, delivered his address on "Social Considerations in the Rehabilitation of the Disabled," illustrated with motion pictures, which will also be published in a subsequent issue of THE MODERN HOSPITAL.

NURSING PROBLEMS—EVENING

When Dr. Ancker opened the Wednesday evening meeting and turned it over to the presiding officer of the eve-

ning, Miss Georgia M. Nevins, chairman of the section on nursing, the main assembly hall was already filled to capacity with an audience keen to hear about the national nursing problems. A spontaneous burst of applause greeted the introduction of Miss Annie W. Goodrich, dean of the Army School of Nursing (representing the Surgeon General of the Army) who read a paper on "The War Department Program for the Nursing Care of the Army," which will appear in a subsequent issue.

In the absence of Miss Mary Beard, the president of the National Organization for Public Health Nursing, who was on the program for a paper on "Public Health and Nursing of the War" the paper was read by title and Mrs. Helen Hoyt Greely, counsel for the National Committee to Secure Rank for Nurses, was given an opportunity to present the issues involved in the desire of nurses for military rank and to urge support of the Lewis-Raker bill, giving rank to nurses. Mrs. Greely pointed out that rank was desired by the nurses in order that they might use it as an instrument of efficiency and not as a matter of convenience to themselves. Among the tens of thousands of orderlies in the various military hospitals, many were not instructed in respect for the nurses and, in the absence of any outward visible sanction of authority, the nurses were subject to many humiliations at the hands of the orderlies. Mrs. Greely pointed out that Canada and Australia have rank for nurses from major down to second lieutenant, and urged that we follow their example.

The adoption of the following resolution was then moved by Dr. A. R. Warner, of Cleveland, and was enthusiastically adopted:

WHEREAS, Under the present system the right of nurses of the Army Nurse Corps to exercise authority over enlisted men assigned to duty in military hospitals is frequently disputed by hospital corps men, ward masters, and noncommissioned officers, because the status of the nurses is not well understood and their position and powers are described only in regulations in books not familiar to the men; and



MR. PLINY O. CLARK.

Superintendent, Ohio Valley General Hospital, Wheeling, West Virginia

WHEREAS, This questioning of their authority results not only in unfortunate friction and a disturbed morale but frequently in serious delay in the execution of important orders; and

WHEREAS, Enlisted men have learned through instruction and discipline in established army practices to look for and respect the external evidence of authority in the insignia of rank; and

WHEREAS, The conferring of rank upon nurses would place upon them that outward badge of authority so essential in a democracy where one does not by nature take orders unless assured of the unquestioned right of another to give them; and

WHEREAS, There is before Congress a bill contemplating the conferring of relative rank upon nurses; and

WHEREAS, This relative rank does not involve the actual commissioning of nurses, nor give them the pay, allowances or emoluments of the rank, nor yet the power of command incident to a line officer of similar grade, but gives only the right to wear the insignia of the rank and eligibility to exercise authority only in medical and sanitary matters and other work in the line of their duties in and about military hospitals next after the medical officers of the army; and

WHEREAS, The conferring of certain relative rank upon the nurses would greatly contribute to the efficiency of their service; and

WHEREAS, The experience of the Australians and the Canadians, both of whom have conferred relative rank upon their nurses, has demonstrated the wisdom of drawing an unmistakable line of demarcation between nurses and enlisted men and of classing all nurses with officers; therefore be it

Resolved, That we heartily endorse the conferring of relative rank upon nurses; that we deplore and condemn the idea of conferring upon any nurse any rank lower than of a second lieutenant; and that we urge the immediate passage of the Lewis-Raker bill, which proposes rank as follows: For the superintendent of the army nurse corps, relative rank of major. For the assistant superintendents; directors and assistant directors, relative rank of captain; for chief nurses, relative rank of first lieutenant; for nurses, relative rank of second lieutenant; and be it further

Resolved, That a copy of these Resolutions be sent to the President and Vice President of the United States, the Secretary of War, the Secretary of the Navy, the Surgeon Military Affairs of both the Senate and the House of Representatives.

The resolution was unanimously adopted.

The subject of "The Red Cross Nursing Service" was presented by Miss Jane A. Delano, director of the Department of Nursing, American Red Cross, whose paper also appears in this issue.

The last paper of the evening was that of Miss Adelaide Nutting, of the Teacher's College, Columbia University, who is acting as chairman of the Committee on Nursing, Council of the National Defence. Miss Nutting's paper appears in this issue.

Mr. Richard P. Borden, who was called upon by Miss Nevins, the chairman of the meeting, to open the discussion, questioned the wisdom of some of the plans that had been outlined in the papers that had been read. He contended that if the plans for the Army Training School for Nurses were carried out on a large scale they would seriously handicap the civil hospitals, since many of the latter are already suffering from the lack of trained supervisors. Just as we are sending millions of men to the front to do a particular piece of work, so, he said, women who are anxious to do their bit but who have no desire to enter the nursing profession should receive special education in their particular line of duty instead of being required to take the full nurse's training course. He contended for a wide use of hospital assistants trained on a standardized basis. He regretted that the program supported by the previous speakers had been adopted without due consultation with civil hospitals.

Miss S. Lillian Clayton, of Philadelphia, replied that the plans for affiliation of the Army School for Nurses with the civil hospitals had not been adopted without consultation with the civil hospitals, and referred to resolution of endorsement adopted at the last meeting of the national nursing organizations.

Dr. C. O. Young, of Chicago, a delegate sent by the governor of Illinois, asserted that, notwithstanding the resolution referred to, the hospitals themselves, their boards of trustees, etc., had not been consulted.

Dr. S. S. Goldwater, of New York, said that he did not despair of the ultimate outcome of the nursing problem when he saw the army, step by step modifying its plans to meet the actual needs as they arose from time to time.

He sketched the three stages through which the problem of supplying the army with an adequate nursing service had passed. The first step involved the enrollment of graduate nurses; the second the launching of the Army School for Nursing, which he characterized as a well-intentioned purpose but rather loosely organized; and finally the adoption of a plan for the education of hospital assistants.

In speaking of the Army School for Nursing, he dwelt upon the inadequate clinical material which the army hospitals afforded and showed how it led to the first modification of the plan, namely, the affiliation of civil hospitals. He felt that the difference between the civil schools and the army schools in the sequence pupils are admitted, presented a difficult problem from the standpoint of organization. He felt that the plan was dangerous from the standpoint of downright morality, when it is not known what resources we have for the training of these women. Dr. Goldwater felt that now that the third step had been taken, namely, the adoption of the plan of training hospital assistants, the only difference between the two opposing schools on this subject was the question of what should be the relative proportion between the graduate nurse, the pupil nurse and the hospital assistant. It was Dr. Goldwater's opinion that if the war continues very long, hospital assistants will have to be used very freely in both civil and military hospitals.

MORNING, SEPTEMBER 26

The report of the Committee on Institutional Membership, which has already been published in THE MODERN HOSPITAL, was presented, and adopted with one amendment, offered by Mr. Richard F. Borden. The adoption of this measure is one of the most important achievements of this meeting.

Mr. Michael M. Davis, Jr., chairman of the Committee on Out-Patient Work, read the report of that committee, which was adopted. The report of this committee will be published later in THE MODERN HOSPITAL.

Mr. N. V. Perry then read a paper on "Hospital Construction," illustrated with lantern slides. This will also appear later in this journal.

EVENING, SEPTEMBER 26

One of the most interesting, practical, and successful sessions held during the entire convention was not scheduled on the program—one at which no papers were read and no resolutions presented. Mr. Asa Bacon, superintendent of Presbyterian Hospital, Chicago, elected chairman of this meeting, held Thursday evening, stated that the purpose was to take the place of a question box.

Dr. Moss, of Baltimore, presented five questions: (1) How can we get and keep domestic help? (2) How can the shortage of interns be made up? (3) Considering increase in expense, how can we increase our income? (4) How can we supply the shortage of orderlies? (5) Shall the hospital receive those applying for rest cures?

(1) Among the replies to the first question were the following: "Introduce machinery. Set up cafeteria for help." "Feed them better." "Furnish proper housing, feeding and pay." "We have a welfare worker and all kinds of amusements." "Munitions workers get \$7 a day. Hospital offers \$35 per month." "We use Japanese help." "Government should regulate these high wages." "Tuberculosis hospital uses improved patients; pays them \$20 to \$30 per month." Mr. Test, of Philadelphia, asked, "Why not get volunteer help, both men and women? I have a society girl who works from 6 a. m. to 6 p. m. six days a week." Others suggested, "We have a volunteer working to re-

lease graduates." "We have a volunteer making dressings." "Society voluntary help is irregular." "We use half crippled men, at \$40 per month." "Hospitals should be classed as essentials." "We have volunteers making dressings and sewing." "We use old men and handicapped men." "Prohibition will help." "Eight-hour day, \$35 to \$45 per month."

(2) The question about the method of meeting the shortage of interns was answered by St. Luke's, Cleveland, to the effect that half the usual number of interns did full work when paid. Another institution expects the compulsory intern year to cover the need.

(3) The question in regard to ways of increasing income was answered as follows: "Exchange garbage for soap." "Charge more." "Charges in Providence have already been raised from \$12 to \$17.25 and from \$21 to \$24.50." "Presbyterian Hospital in Chicago has made a small raise in wards, 25 cents a day, and a large raise in private rooms." "Set a daily rate and not a lower rate. Give charity outright." "We increase our income by using the interns private dining room. We forced county to raise pay from \$1 to \$2 per day." "It is possible to get more money from ward patients. Our investigator saved us more than three times his salary by close investigation." "Investigate all departments closely to shut off waste." Various reports were made on per capita cost for ward patients, including \$1.64 per day in California, \$1.59 in South Carolina, \$2.10 and \$2.67 in Pennsylvania, \$2 in Oklahoma, \$2.16 in Toronto, Canada, \$2.25 in Ohio, \$2.85 in Chicago, and \$3.50 in New York. The question, "What does per capita cost mean? What do you give?" brought out that the x-ray charge in Chicago varied from zero to \$25, and that operating room charge varied from \$2.50 to \$15. The suggestion was made to adopt a uniform x-ray charge according to plate, charging war patients one-half. A second suggestion was to place all x-ray workers on salary and let the hospital get the profit. Other suggestions were to charge at cost for drugs, etc., and to make daily charge cover free dressings and medicine. Maternity cases are charged all the way from \$1 per day to \$2.75. Most hospitals charge from \$1.50 to \$2 per day with no charge for entrance. Some hospitals charge 50 cents per day for new-born babies, and others from \$5 to \$7 per week.

(4) Among suggestions as to the way of meeting the shortage of orderlies were: "Get older men." "Replace men with women, as far as possible." "Get the government to lend us soldiers to train." "Get professors and school masters." "One hospital is trying high school students." "Employ aliens." "Substitute women and children." Montreal Hospital has eliminated indoor orderlies.

(5) Shall the hospital receive those needing the rest cure? Few say shut them out; few say take them in; the rest are indifferent. Mr. Test says, "Treat patients as normally as possible, taking all that require hospital care, no matter what their complaint may be."

A query was presented by a puzzled business man, "What can a hospital having no dispensary do in the venereal disease campaign?" The only answer was, "Open one." He was finally referred to expert headquarters. This query brought out the fact that Mr. Michael M. Davis Jr., says most of this work must be done in small towns. Mr. W. J. Clark, Columbia, S. C., says the government furnished a needed dispensary. Others say that the local health officer should. The business man said that the attitude of the local practitioner was discouraging to the hospital; therefore, the trustees were afraid to undertake the expense. The doctors were cynical or antagonistic.

As to the question of reporting venereal disease, they felt the publicity in small towns to be feared, which made a deadlock in small communities. He was told that any health officer can compel treatment of quarantine.

Quotations as to salaries of night supervisors ran from \$50 to \$85 per month; of head nurses, from \$65 to \$100 per month. Interns are receiving from \$10 to \$150 per month. Nurse anesthetists from \$1,000 to \$2,000 per year. This raised the question of the responsibility of nurse anesthetist and medical student anesthetist. The employment of nurses anesthetists is legal in Pennsylvania, illegal in Providence, R. I. Nurses are good as anesthetists. Employer of a nurse really should be responsible.

MORNING, SEPTEMBER 27.

The secretary announced that 483 members, delegates and guests had registered. This number, together with the commercial exhibitors, who numbered 100, made a total registration of 583. Thirty-four states were represented. Pennsylvania had the largest representation, 76, while New York came second with 58. There were 99 delegates present, who were appointed by the governors of 26 states. The representation from west of the Mississippi River was most gratifying.

The secretary called attention to a letter which he had received from the Fuel Administration urging the conservation of fuel by the hospitals of the country.

Mr. Howell Wright, chairman of the Standing Committee on Legislation, read the report of that committee, which is presented elsewhere in this issue.

One of the most interesting and instructive papers of the convention was that on "Hospitals and Health Insurance," by Mr. John A. Lapp, the director of investigation of the Ohio Health and Old Age Insurance Commission, which will be published in *THE MODERN HOSPITAL*.

In the discussion of Mr. Lapp's paper the convention's attention was called to the fact that one of the large mutual insurance companies is considering the establishment of hospitals of its own, in communities where there were large numbers of insured, because they found they could get better service at less expense than in general hospitals. Mr. Barrow B. Lyons, of Wilmington, Delaware, presented an interesting analysis of the reasons why he thought people desired to be in control of hospitals: (1) because they were anxious to relieve physical suffering; (2) because they were anxious to relieve future suffering by raising the health standard of the community; (3) because they desired to win social recognition; (4) because they liked to exercise authority; (5) because they wish to win a place in Heaven!

Mr. Frederick Greene, of the United Hospital Fund of New York, showed how, by an analysis of statistics which the fund had secured from forty-six leading hospitals which were members of the fund, facts had been secured which were very helpful to the hospitals in enabling them to secure a fair payment for the services which they rendered to the community.

Mr. Lyons thought it was within the power of the association to bring before the public those cases in which insurance companies are delinquent in settling their accounts with hospitals.

Following the discussion of Mr. Lapp's paper, Mr. Borden, the chairman on resolutions, presented ten or eleven resolutions, all of which were unanimously adopted and appear elsewhere in this issue of *THE MODERN HOSPITAL*.

The report of the Nominating Committee was read by Colonel Lewis R. Baldwin, Minneapolis, chairman of the Standing Committee on Nominations. The committee

made the following nominations: President, Dr. A. R. Warner, superintendent Lakeside Hospital, Cleveland, Ohio; first vice-president, Dr. Joseph B. Howland, acting superintendent Massachusetts General Hospital, Boston; second vice-president, Mr. A. B. Tipping, superintendent Touro Infirmary, New Orleans, La.; third vice-president, Sister Irmena, president Missouri Catholic Hospital Association, St. Louis; treasurer, Mr. Asa Bacon, Chicago; executive secretary, Mr. Howell Wright, Cleveland, Ohio; trustee for five years, Dr. Robert J. Wilson, Department of Health, New York, N. Y. These men were unanimously elected to their respective offices for the coming year, the question of Mr. Wright's salary as executive secretary being referred to the board of trustees.

Dr. Warner, in accepting the presidency, stated that he could not conceive of any election that could give him greater satisfaction than his election to presidency of the American Hospital Association. He felt that the election was more than an ordinary honor, as it was more than he had reason to expect, inasmuch as last year he had refused the nomination without giving his reasons for doing so.

The concluding paper of the Friday morning session was one by Dr. Warner, devoted to the subject of social service and hospital efficiency, which is published in THE MODERN HOSPITAL. Dr. Warner stated that social service to be efficient required a thorough knowledge of the medical questions involved; a far-reaching knowledge of sociology; and a mature judgment of what is best to be done in given cases. In conclusion, he urged that universities be persuaded to give special courses in hospital social service work. This recommendation was embodied in the following resolution, which was unanimously adopted:

Resolved, That the American Hospital Association express a recognition of a general need of a large number of women to supervise hospital social service work, who shall have the advantages of training by a university in preparation for such work; that the essential elements in such an education are (1) general educational; (2) medical; (3) sociologic; and that this work be so combined as to make a university course of reasonable length; and be it further

Resolved, That the executive secretary shall send copies of this resolution to such universities as do now give practical courses in philanthropy and sociology and to any other universities contemplating the establishment of such courses.

EVENING, SEPTEMBER 27

The Friday evening meeting, which was a joint general session of the American Hospital Association and the American Dietetic Association, was called to order by Dr. Warner, the president-elect of the American Hospital Association.

The secretary announced that a communication regarding the newly established institutional membership, would go out to the membership of the association as soon as possible.

The report of the auditing committee was read by Mr. Cornelius S. Loder and accepted by the association.

This was followed by the report of the Committee on Time and Place. This committee reported that, after taking account of the factors of accessibility, accommodations for exhibitors, hotel accommodations and hospitals and entertainment, it recommended: (1) that the invitation of the city of Cincinnati, Ohio that next year's convention to be held there, be accepted; (2) provided that, if in the judgment of the board of trustees of the association another city proves more desirable, the board of trustees be given authority to make the change; (3) that the board of trustees be empowered to set the time of the convention between September 1 and October 15, 1919, as it may think best. This report was unanimously accepted.

In very happy language, Mr. Daniel Test, referring to four hospital superintendents who, at the beginning of his career as a hospital superintendent had been exceedingly helpful to him, paid Dr. Ancker, who was one of them, a glowing compliment on his work for the association during the past year. On behalf of the association, Mr. Test also expressed appreciation to the secretary, the treasurer, the trustees, and the chairman of the war service committee of the association, as well as to the public press, the local committee and the mayor of Atlantic City.

At the conclusion of Mr. Test's speech, the meeting was turned over by Dr. Warner to Miss Cooper, the vice-president of the American Dietetic Association.

Mr. Henry C. Wright, the secretary of the New York State Charities Aid Association, addressed the convention on the subject of institutional food conservation, and told of the work of the division of the National Food Administration dealing with the conservation of food in institutions and college dining halls. Speaking broadly, he dwelt upon the two main subjects of the readjustment of the dietary and how to save food as well as readjust the dietary. He commended the policy of the government in conserving food by the voluntary effort of the citizens of the country. He felt that the results in food conservation were a demonstration of what a democratic people can do when they think it ought to be done. The government, after establishing its program of food conservation, was obliged to take the next step and show the people how food could be conserved. This resulted in the appointment of a number of committees, of which the committee dealing with institutions, both public and private, and college dining rooms was one.

The main food items which the government has asked institutions to save are wheat and wheat products, meats, fats and sugars. As conditions in different parts of the United States vary, and as food varies with the seasons, no specific recommendations could be made by the committee for general application. The committee therefore collected a group of well known diets which are being sent to various institutions of the country as illustrative of the way in which the use of these main food staples may be reduced.

In developing the question of how food can be saved Mr. Wright contended that in order to save food it is of prime importance for the superintendent of the institution to know how much food comes from the storeroom, how much comes out of the kitchen and how much goes to the service rooms. He referred to a pamphlet which will shortly be issued by the government describing a waste system which has been used successfully in a number of states and which has proved practical and exceedingly economical. In concluding his remarks, Mr. Wright referred to the cafeteria system as a possible means by which institutions may conserve food.

Mr. Pitcher of Kings Park State Hospital, Kings Park, L. I., then read a paper on the subject of waste in the preparation, cooking and serving of food. The paper presented a variety of valuable detail on this subject and will be published in a later issue of this magazine.

Miss Lulu Graves, editor of the Dietetics Department of THE MODERN HOSPITAL, then read her paper on "The Management of the Dietary Department of the Hospital," which will be published in a later issue of THE MODERN HOSPITAL.

Following a very brief discussion of Miss Graves' paper Miss Lenna Cooper of the Battle Creek Sanitarium said:

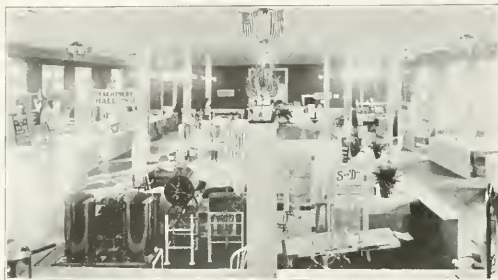
"It may be that I shall throw a bomb into the camp when I say that, on top of the demand for nurses and surgeons for the army which has been made upon hos-

pitals, there is a strong possibility of the necessity of hospitals sparing their dietitians. Either the civil hospitals must spare their dietitians or others must be found very quickly."

Miss Cooper then introduced Miss Fisher of Teachers' College. Miss Fisher said that the Dietitians Committee of the Nursing Section of the American Red Cross expected hospitals which now took student dietitians to take more, and expected the others who did not take student dietitians to make provisions to do so. She said that the committee recommended a four months' course, information regarding which

Mr. Asa Bacon, superintendent of the Presbyterian Hospital, Chicago, reported that his institution had, as a patriotic duty, increased its nursing school by 25 per cent. "We moved our maids into two houses in the rear of the home and gave their beds to pupils. At present we have

26 nonresident pupils paying their own room rent. We are able to provide sufficient training for this increase without lowering the standard. We have sufficient pupils booked to 1920. So far the nonresident plan has been quite satisfactory under the supervision of the principal of the school." In response to questions, Mr. Bacon said that the Presbyterian Hospital had in-



Commercial Exhibits, Atlantic City Convention, American Hospital Association



would be gladly furnished by Miss Elva George, director of the Dietitian Service of the American Red Cross.

CONVENTION FEATURES TO BE DESCRIBED LATER

Next month will appear a comment on the commercial exhibit; also a complete report of the meeting of the American Dietetic Association and the section on dietetics of the American Hospital Association. Some of the papers read in the general and section sessions appear in following pages of this issue; others will be published in later issues of THE MODERN HOSPITAL.

SECTION MEETINGS

Section on Nursing

TUESDAY AFTERNOON, SEPTEMBER 24,

Miss Georgia M. Nevins, chairman of the section and director of the nursing bureau, Potomac division, American Red Cross, presided.

Miss Mary M. Riddle, superintendent of the Newton Hospital, Newton Lower Falls, Mass., author of the first paper on the program, called "How to Secure the Best Results for Students for Those Schools Which Have Patriotically Increased Their Nurses on Account of War Conditions," was not present, and her paper was therefore read by Miss Jessie L. Catton of St. Luke's Hospital, St. Paul, Minn. Miss Riddle's paper will be published later.

The chairman then asked how many superintendents present represented hospitals which had patriotically taken a larger number of nurses than would have been needed under ordinary conditions. The number of hands raised indicated that a considerable number had taken on an increased number.

creased its school facilities in the occupational and other departments and that no trouble with discipline had resulted from the admission of nonresident students.

To the question whether anyone had permitted student nurses to remain in their own homes, Miss C. Irene Oberg of Elgin, Ill., responded that two students in her school were living in their own homes.

The point having been raised that, as in other schools, the nonresident students were less likely to become imbued with the spirit of life in the school, Mrs. Helen DeSpelder Moore of Jackson, Mich., reported that their one student nurse permitted to remain in her own home was one of the most enthusiastic supporters of the school life and activities.

Miss Mary L. Keith, superintendent of Rochester General Hospital, Rochester, N. Y., then read a paper on "Triple Alliance of Nursing Interests." Miss Keith described an educational experiment instituted in three schools of Rochester which had problems in common. Hospital 1, an institution with 280 beds, had lost its superintendent of nurses, its practical instructor, its night supervisor, its operating room supervisor and its social service secretary. Hospital No. 2, with 150 beds, had parted with its superintendent of nurses to the army service and promoted its instructor to the vacant position; it had also lost its operating supervisor and maternity head nurse. Hospital 3, with 140 beds, had made sweeping changes in management. A new superintendent of nurses was trying to raise a first-class school out of ashes of a third rate school.

The problem that confronted the three schools was, although no first-class instructors could be obtained for love or money, to take in, as a patriotic duty, more probationers and train them better and more rapidly, and to maintain higher efficiency than ever before. It was decided, as a first step in the solution of this problem, to pool the assets and liabilities of the three institutions, so far as the preliminary course of instruction extending over thirteen weeks was concerned, with the motto, "All for each and each for all." Each school accepted its own probationers for the September course. No. 3 accepted twenty-one, No. 2 twenty-four, and No. 1 thirty-five, making eighty in all. Of the three schools No. 3 had had a systematic course and was ready for any progressive step. No. 2 had one instructor for both theory and practice. No. 1 had an embryo practical instructor and was about to lose its theoretical instructor. This theoretical instructor had unusual qualifications, including college preparation, but after four years' work in the school of the hospital, she advanced to the limit of all that institution had to offer in either money or experience and was ready for larger fields. She was released from residence at the hospital and from all routine, except that of academic instructor, and was re-engaged as director of instruction for the three schools.

The largest school pays half of her salary and the other two pay one-quarter each. This director now lives in a cozy little suite in a central locality and goes forth thence each week-day to teach. Her first class begins at 9 a. m., and her last one ends at 5 p. m., except on Saturday, when the hours are shorter. She takes time for lunch and gets air and exercise going from one hospital to another. Her evenings and Sundays are free. Each hospital has a resident graduate assistant instructor and each of these assistant instructors has as her assistant a third-year pupil. It is a great honor to be chosen as a student assistant instructor, and the selection is very carefully made. The assistant thus chosen is receiving training for teaching work. As the student assistant is changed from time to time, there are each year several pupil nurses receiving training for teaching positions on graduation.

The director has full control of all assistants and plans all the schedules. This is the hardest part of the work. Each school has its own class room, and the standardized equipment is the same in all; so also are the methods of procedure taught. The note which is most loudly and most frequently struck in all the teaching, is that all theory is to bear out practice and that no theory is of value unless it can be used.

The experiment has been more than a demonstration of the value of cooperative teaching. It has also been a study in ethics and psychology and sociology. Within Miss Keith's memory, the superintendents of these several hospitals were not on speaking terms with each other, and the three institutions, as a matter of course, practiced destructive competition. The fact that cordial and friendly relations are now maintained among the three schools is perhaps the more striking because of the fact that one institution represents the regular school of medicine, while the other two are the Hahnemann Homeopathic Hospitals.

The beginning of the experiment in cooperation probably dates back to 1917, when Hospital No. 1 lost its laboratory forces to the army. There was no one to do the work, and the laboratory and equipment deteriorated. One of the hospitals had a pathologist and two technicians, money and equipment; it had nothing tangible to gain by affiliation. By action of its board, however, it did affiliate with the needy hospital and its pathologist became the pathologist of the two hospitals on a fifty-fifty basis.

The pathologist selected and trained two technicians for the hospital which had lost its force. Now in case of exigencies the forces of the two hospitals are used interchangeably.

Miss Flaws of Toronto, Canada, reported that in her city eight schools had combined to train their student nurses, not, however, during their probationary period. In the senior year social service and pediatrics were given on a cooperative basis; in the intermediate year, surgery and gynecology, and in the junior year bacteriology and medicine.

Miss Nevins, chairman of the section, made the point that this cooperation among schools of nursing meant getting away from petty and ridiculous jealousy and toward the factor which is looming so large in the future of hospitals, namely, standardization.

As Miss Isabel M. Stewart, of Teachers' College, was not present, her paper on "The Vassar Training Camp" was not read.

AFTERNOON, SEPTEMBER 27

A paper on "The Summer Course at Western Reserve University," by Miss Claribel A. Wheeler, principal of Mount Sinai Hospital School of Nursing, Cleveland, Ohio, was read in the author's absence. This paper will be published in THE MODERN HOSPITAL.

In discussion on this paper, Miss Maude Landis, of New Haven, Conn., outlined work which is being done to raise the standard of the Connecticut Training School.

Miss Harriet Frost, head of the teaching department of the Visiting Nurse Society, Philadelphia, then read a paper on "The Training of Third-Year Students in Public Health Nursing," which will appear in a later issue of this journal.

In reply to a question from Miss Nevins in regard to the way in which the training of pupil nurses is done, Miss Frost replied that two months' training is given now and four months is hoped for. Most pupils live at their own hospitals.

Miss Mary E. Lent, director of nurses, United States Public Health Service then read her paper on "Public Health Work in the Sanitary Zones."

This was followed by the paper of Miss Isabel M. Stewart, of the Department of Nursing and Health, Teachers' College, New York, on "The Vassar Training Camp," which had been omitted from the Tuesday session. It will appear in a later issue.

* * * *

Sections on Out-Patient Work and Social Service

JOINT MEETING, TUESDAY AFTERNOON, SEPTEMBER 24

Noteworthy because of its spirited speeches and discussion was the meeting on Tuesday afternoon of the Sections on Out-Patient work and on Social Service, which were combined because of the unavoidable absence of Mr. John E. Ransom, superintendent of the Central Free Dispensary, Chicago, who was acting as chairman of the Section on Social Service. Mr. Michael M. Davis, Jr., chairman of the Section on Out-Patient Work, presided. The subject under discussion, "Fighting Venereal Diseases: A National Program Calling for Dispensary Service," was handled in a very able, spirited manner by Maj. Alec N. Thompson, who represented both the Surgeon-General of the Army and the United States Public Health Service.

Major Thompson sketched the inception of the movement which led to the adoption of a nation-wide program for the control of venereal diseases as a war measure. As part of this program the Surgeon-General has invited the various states to avail themselves of the offer of the Federal government to place an officer especially trained

in venereal disease work in each state department of health. The government, moreover, has passed the Chamberlain-Kahn bill, providing \$1,000,000 for the purpose of subsidizing the venereal disease control work in the various states. This year the subsidy is based on state population. Next year, however, it is proposed to subsidize each state on the basis of what it is willing to invest in this work.

Major Thompson indicated that the national program involved the development of diversified public health activities, including the reporting of acutely infectious cases, the detection of carriers, the isolation of "incorrigibles," treatment facilities in hospitals and dispensaries, the education of the public, adequate laws and the strict enforcement of those laws. The whole program was based, he stated, on the principle that continence is compatible with health and the best preventive of venereal disease. He urged the hospitals to cooperate in carrying out this program by opening their doors to patients suffering from these diseases, declaring that any institution which refuses to treat venereal disease is not doing its bit. He quoted some figures showing that, during the last nine months, 39,425 cases of venereal disease existed in the army, only 4,106 of which were contracted after enlistment. He contended that if the men had had hospitals and dispensaries to which they could have gone for treatment instead of only quacks and drugstores this number might have been greatly reduced.

Major Thompson dwelt on the extent of venereal disease, stating that in communities where there is an adequate reporting system, venereal diseases stand next to measles in extent, and are almost as widespread as tuberculosis. As indicative of their cost to the community, he stated that Massachusetts alone was spending \$750,000 a year for the care of its syphilitic insane.

Marked applause was elicited by the statement that it has been shown by actual statistics that the present United States army is the cleanest army of any army in any war in the history of the world. Whereas in 1916 the annual rate was ninety-one per thousand, the present rate in the American Expeditionary Forces is twenty per thousand. The army, finding that, of the women picked up on the street, 95 per cent have gonorrhea and 53 per cent have syphilis, has carried on an active campaign against vice districts.

Every effort is being made to teach the soldier that he cannot fight right if he takes his pleasure under a red lantern. Major Thompson stated that the army's program calling for the cooperation of the owners of department stores and industrial plants would create a demand for greater clinical facilities for treatment which the hospitals would be forced to meet. He urged that clinics be established and that they become trading centers for the patients as well as treatment centers, since there you get your best converts who will spread the gospel of a clean life. He maintains that venereal disease clinics can be established at slight expense and that, as pay clinics, they can be made self-supporting. He cited interesting figures from the Brooklyn Hospital's venereal disease clinic, showing its growth from 1912 with two thousand treatments to 1917 with three thousand treatments.

In carrying out this program Major Thompson said they found the doctors the chief obstructionists; the ministers were second, and the legislators next. But the public is being rapidly educated and is demanding adequate facilities for treatment.

Major Thompson's address was followed by a paper by Miss Ida M. Cannon, chief of the Social Service, Massa-

chusetts General Hospital, on the "Relation of Social Service to the Successful Treatment of Gonorrhea and Syphilis in Hospitals and Dispensaries."

Miss Cannon contrasted the traditional attitude of many hospitals to which persons suffering from alcoholism and venereal disease are not admitted, being victims of their own sensual indulgence, with the condition in 1916, when a survey showed that, of 126 social service departments, fifty were giving special attention to syphilitic patients, thirty-nine to gonorrhea in children, and thirty-one to gonorrhea in adults.

The work of the social service worker in relation to the treatment of these diseases involves personally meeting and conferring with the patient regarding treatment, placing responsibility for payment of fees, rounding up for examination other members of the family, giving superintendent data on which to base remission of fees, interpreting the law to the patient as a war measure, and educating the patient as to the need of the specialist.

* * * * *

Section on Out-Patient Work

SEPTEMBER 26, AFTERNOON

In the absence of Mr. Michael M. Davis, Jr., chairman of the Section on Out-Patient Work, who was obliged to return to Boston, Dr. Robert J. Wilson of the New York City Department of Health, presided.

Because of the omission of the meeting of the Section on Hospital Administration scheduled for the afternoon, the privilege of the floor was given to Dr. Adrian Lambert of the Presbyterian Hospital, New York City, who read a brief paper describing the clinic system of the Presbyterian Hospital. A pamphlet describing this system in detail is now being printed and copies may be had by addressing a request to the Presbyterian Hospital, New York City. The record system of this hospital is an exceedingly efficient one and hospitals generally will do well to study it.

The meeting of the Out-Patient Section was in the nature of a round-table discussion dealing with present dispensary problems.

Mr. Joseph J. Weber, associate director of the Boston Dispensary, spoke briefly on the establishment of the general disease department of the Boston Dispensary. He stated that the Boston Dispensary cooperated with the Massachusetts State Department of Health, and was taking prominent part in the national campaign which the War Department was carrying on for the control of venereal diseases among the civil population. He sketched and described its relation to the State Department of Health, as well as its follow-up system and social service work.

Dr. A. R. Warner, superintendent of Lakeside Hospital, Cleveland, Ohio, described the work now being carried on in the pay clinics of the Lakeside Hospital, dwelling especially upon the thorough-going effort that is made to get the out-patient to return for necessary treatment. Later Dr. Warner was called upon to tell briefly all his experiences in conducting pay clinics at Lakeside Hospital. The subject, he developed along much the same lines as in his paper on the Lakeside pay clinic published in the August issue of THE MODERN HOSPITAL. Dr. Warner emphasized that now many physicians had been called from the community for war service and this was an opportune time for starting pay clinics to meet the needs of the civil population.

Mr. Michael M. Davis, Jr., was reelected chairman of the Section on Out-Patient Work and Mr. Clarence E.

Ford, superintendent of the Medical Institutions of the New York Board of Charities, was reelected secretary.

* * * *

Section on Social Service

AFTERNOON, SEPTEMBER 26

Mr. John E. Ransom, chairman of the section, being unable to be present, and Miss Coombs, the secretary, called away, the meeting was presided over by Miss Ida M. Cannon, chief of social service, Massachusetts General Hospital, and Miss Jarrett was made temporary secretary.

The paper on "A Social Worker at the Admission Desk," by Miss Janet Thornton, registrar of Boston Dispensary, which had been postponed from Tuesday afternoon, was read. Miss Thornton's paper will be published in THE MODERN HOSPITAL.

In discussion, Miss Thornton remarked that all night clinics are pay clinics; free clinics are needed at night. She thinks one reason that so many fail to keep appointments is sometimes rough treatment at the first visit.

In discussing the question of the social worker in relation to the training school, Miss Wadley, of Bellevue, said that she reaches probationers for only a fortnight, but hopes they will remember the training when they leave such service. Their routine is, one day in office—one day in records—attend conferences—visit various societies. In reply to the question whether these probationers retain this social interest, she replied, "Not very well. Institutional work shuts off such social interest." Massachusetts General now likes to take nurses in mid-training for their social service experience. They confer with Miss Lewis on social aspects of syphilis.

Miss Hoyt, of Rochester Homeopathic Hospital, said: "We try to get social point of view over to all pupils during intermediate stages—try to have them handle or study type-cases of tuberculosis, syphilis or illegitimacy."

Miss Mary Antoinette Cannon, of the University of Pennsylvania Training School, says that pupils get two full-time months as social workers, and also study social workers, in morning classes.

Miss Ida M. Cannon, Massachusetts General Hospital, conducts this work herself, taking fourth-year Harvard medical students for two months equaling twelve hours' work for a combination of lecture and case work, which interests them, and giving history talks, a course of six lectures, to second-year men. Case workers are sometimes brought into conference with students. Miss Cannon finds it necessary to make them think of social work as an actual part of medical course. The introduction of some special case does much to arouse human interest.

Miss Farmer, Boston City Hospital, wants to use practical case work rather than lectures.

Mr. John E. Ransom was reelected chairman and Miss Farmer secretary of the section. A resolution presented by Miss Mary A. Cannon, that social workers are greatly needed, was referred to the American Hospital Association Committee on Resolutions.

* * * *

Sections on Administration and Construction

AFTERNOON, SEPTEMBER 27

These two sections held a joint session. The first paper read was "Two Time-Savers," by Dr. L. H. Burlingham, superintendent of Barnes Hospital, St. Louis.

The next paper was by Mr. William R. Ludlow of New York, who strongly urged immediate planning of needed extensions in hospital facilities.

At the close of his paper, Mr. Edward F. Stevens added: "To plan now means a better opportunity for getting bet-

ter results. If we can plan at leisure and devote more time to it, as we can now, it goes without saying that we can get better results."

Mr. Chapman, superintendent of the Mount Sinai Hospital of Cleveland, Ohio, remarked that hospital construction requires more study and detail work than any other kind of building; that hospital plans were often laid without consulting architects, and that in planning hospitals, the advice of architects who have made a special study of the subject should always be obtained.

Mr. Chapman said that more and more hospitals are giving attention to the question of making their rooms more attractive for the patients. "It is remarkable to note the number of hospitals that now have chintz curtains and tinted walls. I believe that we are beginning to get away from the thought that it was a broken leg and his name was John Jones; we are beginning to think a little of John Jones as a human being."

In commenting upon the paper of Dr. Burlingham, Mr. Chapman said, "The number of hospital superintendents that do not know what is going on in regard to the quantity and cost of supplies they are using is appalling; so many of them guess. You ask them if they know how much a certain supply is costing, and they say that they know it is costing more, but they cannot tell you how much more. They have no system whereby the figures come up automatically to show them what is being done."

In answer to questions on his system of handling the institution's laundry, Dr. Burlingham explained: "We try to get a correct inventory of our linen every six months. We take the count of the previous inventory and add the additional amount put into service. Worn-out linen is replaced by new, so that unless actually a larger quantity is being used, there should be no difference in the count. We find that under this system we do not lose as much laundry as under the old system, at least according to our experience within the last four months. However, I do not credit this fact entirely to the new system. It is partly due to the fact that we are marking our linen much more carefully. We also called a conference of our employees and explained to them that taking an article is not 'swiping' but just plain stealing." The surplus linen, Dr. Burlingham said, was kept on shelves in the laundry.

Dr. Neely then read a paper on "War-Time Economies," by Dr. T. A. Devan, assistant superintendent Peter Bent Brigham Hospital.

Mr. Daniel T. Test, superintendent of the Pennsylvania Hospital, said: "We find in the Pennsylvania Hospital, that cooperation and team-work mean as great saving and efficiency as any other factor. Cooperation on the part of our employees is one of the most important things. We call together our doctors, nurses and employees in separate groups about once every two months, and explain to them the costs of the materials they are using, the ways in which they can help economize, the financial condition of the hospital and the need of economy. Even the cooperation of the cleaners in using soap has been of very great benefit. They like this, it pleases the employees. Don't delegate this to your housekeeper or foreman. The help rather like the superintendent to come to them himself. I might also add that we have found the 24 28 gauze tremendously more economical than the 20 24 recommended in Dr. Devan's paper."

Dr. Walker then read Dr. Hersey's paper on "The Hospital Intern," which dwelt with the problem as applying to a very large hospital with a well-organized intern service and affiliated with a teaching institution, rather than to the average hospital which is to be found throughout the country.

Dr. Hurd remarked: "At the present time we are forced to face new conditions and forced to do differently than we shall be able to do after the war. I have been of the opinion for some time that senior medical students could get much more out of their final year by active work in the hospitals. One way in which we can help them to do this is by making it possible for them to spend less time in writing histories and other records. In some places they have used the dictaphone to very good advantage. In other places stenographic help has been provided so that they need merely dictate the history and other records and thus save a great deal of their time. Now that interns are so very difficult for many hospitals to obtain, this seems particularly advisable. In hospitals where it is felt that stenographic aid is too expensive, it has been found possible to secure volunteer workers of considerable intelligence and education, who are willing to do this work without charge for the hospital."

Dr. Neely of the Brooklyn Hospital in commenting upon the possibilities of crowding a more intensive service into the intern year, said that when his interns had been asked if they wished to have their courses on gynecology and obstetrics eliminated, they very strongly protested upon the ground that they wished a well-rounded-out training, which they would not get when they were drafted into the army.

Section on Dietetics

This section met in conjunction with the American Dietetic Association, and a full report of the meeting will appear next month.

* * * *

List of Members, Delegates and Guests Registered at the American Hospital Association Meeting at Atlantic City

The asterisk opposite a name denotes a new member.

- Adeila, Sister Mary..... Wheeling Hospital, Wheeling, W. Va.
 Agape, Sister Mary..... St. Joseph's Hospital, Lancaster, Pa.
 Ahern, D. C..... Supt., Hahnemann Hospital, Chicago, Ill.
 Ahrens, Eleanor..... Supt., Lake View Hospital, Chicago, Ill.
 Aikens, Charlotte A..... Editor of Trained Nurse & Hospital Review, Detroit, Mich.
 Alexander, Dr. James R..... Presbyterian Hospital, Charlotte, N. C.
 Allen, Miss Bertha W..... Lowell General Hospital, Lowell, Mass.
 Altschul, David S..... 71 Park Place, New York City
 Aneker, Arthur B..... President of the American Hospital Association, St. Paul, Minn.
 *Anderson, Emma A..... N. E. Baptist Hospital, Boston, Mass.
 *Anderson, Isabella Craig..... Acting Supt. of Nurses, University of Virginia, Charlottesville, Va.
 Andrews, Miss Fannie N..... Vaughan..... Mission Hospital, Asheville, N. C.
 Appel, Katherine..... Howard Hospital, Philadelphia, Pa.
 Armstrong, D. B..... Framingham, Mass.
 Ashee, Alice M..... New Orleans, La.
 Ayer, Miss Eugenia D..... General Hospital, Elizabeth, N. J.
 Bacon, Asa S..... Presbyterian Hospital, Chicago, Ill.
 Bailey, George J..... Cooper Hospital, Camden, N. J.
 Ball, Dr. O. F..... Modern Hospital, Chicago
 Bancroft, Mrs. Joseph..... Homeopathic Hospital, Wilmington, Del.
 Bannard, Mrs. W. N..... Delaware Hospital, Wilmington, Del.
 Battle, S. W., Dr..... Med. Dir., Clarence Barker Memorial Hospital, Asheville, N. C.
 *Barr, Jos. W..... Oil City Hospital, Oil City, Pa.
 *Barr, Marietta S..... Heywood Memorial Hospital, Gardner, Mass.
 Barnes, Sydney J..... Orange Memorial Hospital, East Orange, N. J.
 Bartine, Oliver H..... New York City
 Bates, F. O..... Roper Hospital, Charleston, S. C.
 Baumannfeld, J..... Evangelical Deaconess Hospital, Chicago, Ill.
 Beers, Mollie..... Cambria Hospital, Johnstown, Pa.
 Behrens, P. W..... Toledo Hospital, Toledo, O.
 Berchmans, Sister M..... St. Joseph's Hospital, Parkersburg, W. Va.
 *Bescherer, Francis H..... Woman's Hospital, Cleveland, O.
 Bernstein, J. M..... Greenville Hospital, Jersey City.
 Betts, Adella A..... N. E. Deaconess Hospital, Boston, Mass.
 Bewley, L. H..... Atlantic City, N. J.
 Bigger, James H..... Western Pennsylvania Hospital, Pittsburgh, Pa.
 *Binkley, Miss Artie M..... Supt., Charity Hospital, Morristown, Pa.
 Bishop, Howard E..... Robert Parker Hospital, Sayre, Pa.
 *Bitzer, Newton E..... St. Joseph's Hospital, Lancaster, Pa.
 Blankenship, Mrs. R. V..... Rex Hospital, Raleigh, N. C.
 Bloxham, Nellie L..... Kimball Hospital, Putnam, Conn.
 Borden, Richard P..... Union Hospital, Fall River, Mass.
 Boteler, M. E..... Children's Hospital, Bainbridge, Ga.
 Boyce, Sister M. J..... Pittsburgh Hospital, Pittsburgh, Pa.
 *Braeken, Dr. H. W..... State Board of Health, St. Paul, Minn.
 Breitzinger, W. M..... Lancaster General Hospital, Lancaster, Pa.
 Briggs, Gertrude A..... Chicago, Ill.
 Brinton, Bessie..... Lakeside Hospital, Cleveland, O.
 *Britton, Harry A., M. D..... Minneapolis City Hospital, Minneapolis, Minn.
 Brobson, Miss Anna K..... Philadelphia, Pa.
 Brodick, R. C..... San Francisco Hospital, San Francisco, Cal.
 Brogan, Miss Margaret S..... Johns Hopkins Hospital, Baltimore, Md.
 Browne, Elsie M..... Douglass Hospital, Philadelphia.
 Browne, Mrs. D. I..... Tulsa, Okla.
 Brush, Edward N..... Sheppard & Enoch Pratt Hospital, Baltimore, Md.
 Bryan, Edith..... Cambria Hospital, Johnstown, Pa.
 Byrne, Jos., M. D..... Fordham University, New York City
 Bunn, F. S..... Youngstown, O.
 Burzan, John..... State Hospital, Scranton, Pa.
 Burlington, Louis H..... Barnes Hospital, St. Louis, Mo.
 Burley, Nelly R..... Richmond Hill, L. I.
 *Burt, Bertha Hart..... Hart Private Hospital, Roxbury, Mass.
 *Butler, Alice, B. D..... Woman's Hospital, Cleveland, O.
 Butterfield, Caroline L..... Martins Ferry Hospital, Martins Ferry, O.
 Caddy, Eva..... Fox Memorial Hospital, Oneonta, N. Y.
 Cain, G. D., Jr..... Chicago
 Cannon, Ida M..... Massachusetts General Hospital, Boston, Mass.
 Cannon, Mary Antoinette..... University Hospital, Philadelphia
 Chapin, M. K..... The Modern Hospital, Chicago, Ill.
 Castlelaw, Rush E..... Wesley Hospital, Kansas City
 Catton, Miss Jessie E..... St. Luke's Hospital, St. Paul, Minn.
 Chapman, F. E..... Mt. Sinai Hospital, Cleveland, O.
 Chappell, Frances..... St. Luke's Hospital, St. Louis, Mo.
 Christianson, A. Jeanette..... Northwestern Hospital, Minneapolis, Minn.
 Clark, J. Cleveland..... Springfield Hospital, Sykesville, Md.
 Clark, P. O..... Ohio Valley General Hospital, Wheeling, W. Va.
 *Clark, W. Julian..... Columbia Hospital, Columbia, S. C.
 Clayton, Lillian S..... Supt., Philadelphia General Hospital, Philadelphia, Pa.
 *Cleave, K. Frances..... Samaritan Hospital, Philadelphia, Pa.
 Cleveland, Edw. H. Rev. Supt., Hospital for Consumptives, Inwood-on-Hudson, N. Y.
 Coleman, Louise M..... House of the Good Samaritan, Boston, Mass.
 Cole, C. G..... State Presbyterian Hospital, New Orleans
 Combs, Mary H..... 405 Lexington Ave., New York City
 Conley, Dr. Walter H..... Metropolitan Hospital, Blackwell's Island, New York City
 Condon, W. M..... Harrisburg Hospital, Harrisburg, Pa.
 Cope, John Purdy..... General Hospital, East St. Louis, Mo.
 *Cowan, Mary..... Presque Isle Hospital, Presque Isle, Me.
 *Covles, Annette B..... Maternity Hospital, St. Louis, Mo.
 *Cock, Dora E..... Roanoke Rapids Hospital, Roanoke Rapids, N. C.
 Cooper, Lenna..... Sanitarium, Battle Creek, Mich.
 Cratty, John M..... Presbyterian Hospital, Philadelphia
 Crew, E. R..... Miami Valley Hospital, Dayton, O.
 Crlehiowski, W. P..... Wawatosa, Wis.
 Cunnings, Margaret M..... Christian H. Buhl Hospital, Sharon, Pa.
 Cuth, Helen L..... 426 E. 26th St., New York City
 Davis, Nellie..... Erie County Hospital, Buffalo, N. Y.
 Davis, Michael M., Jr..... Boston Dispensary, Boston, Mass.
 Davis, Nina..... Kings' Daughters Hospital, Staunton, Va.
 Davidson, S. G..... Samaritan Hospital, Philadelphia, Pa.
 Deaver, Mary F..... Christ Hospital, Cincinnati, O.
 Denton, Emily, Miss..... General Hospital, Saranac Lake, N. Y.
 *DeWitt, Dr. H. K..... Department Hospital and Dispensary, Buffalo, N. Y.
 *DeWitt, Mrs. W. E..... Saginaw General Hospital, Saginaw, West Side, Mich.
 Diehl, Charles F..... Flower Hospital, New York City
 *Dolorosa, Sister Mary..... St. Catherine's Hospital, Brooklyn, N. Y.
 Dougherty, Fannie A..... Cottage State Hospital, Philadelphia, Pa.
 Dowling, D. G..... Hahnemann Hospital, New York City
 Duffy, Rev. E. P..... St. Vincent Charity Hospital, Cleveland, O.
 Dolan, Thomas E..... Receiving Hospital, Detroit, Mich.
 Dwyer, John R..... Omaha, Neb.
 Durnin, Mary..... Danbury, Conn.
 Dreyfoos, Dr. M..... Jewish Hospital, Cincinnati, O.
 Daniel, Mrs. Gertrude..... Domestic Science Dept., Brookline, Mass.
 Eager, Mary L..... Rush Hospital, Philadelphia, Pa.
 Ebbert, L. Hilda..... Springfield Lake Sanatorium, Akron, O.
 *Ebendick, Mrs. Julia..... City Hospital, Lockport, N. Y.
 Eckman, Rena S..... Columbia University, New York City
 *Egbert, Carrie..... Woman's Hospital, Detroit, Mich.
 *Egualia, Sister M..... St. Joseph's Hospital, Baltimore, Md.
 Emmott, Susan E..... St. Luke's Hospital, New Bedford, Mass.
 Essig, Anna K..... Coatesville Hospital, Coatesville, Pa.
 Etheldreda, Sister M..... Mercy Hospital, Pittsburgh, Pa.
 *Eugenia, Sister M..... Mary Immaculate Hospital, Jamaica, L. I.
 English, Samuel B..... N. J. State Sanatorium, Glen Garden, N. J.
 Fay, John E..... Ellis Hospital, Schenectady, N. Y.
 *Faylor, Grace..... Alexander Hospital, Montreal, Can.
 Farmer, Miss Gertrude L..... Director City Hospital, Boston, Mass.
 Ferguson, Irene M..... Supt., Santa Filomena Sanatorium, San Francisco, Cal.
 Fesler, Paul H..... Supt., University Hospital, Oklahoma City, Okla.
 Franklin, J. B..... Baptist Sanitarium, Dallas, Tex.
 *French, Nellie S..... Supt., St. Luke's Hospital, Bluefield, W. Va.
 Friedman, Nina Dale..... Supt., Grant Hospital of Chicago, Chicago, Ill.
 Fonksrud, A. O..... Supt., Norwegian Hospital, Brooklyn, N. Y.
 Ford, Clarence E..... The Capitol, State Board of Charities, Albany, N. Y.
 Ford, Mrs. A. L..... Children's Hospital, Pittsburgh, Pa.
 Fowler, Benj. M..... Supt., Vassar Bros. Hospital, Poughkeepsie, N. Y.
 Fulgentia, Sister M..... Supt., St. Francis' Hospital, Trenton, N. J.
 Fleet, J. W..... Potsville, Pa.
 Flaws, Eliz. G..... Supt., Wellesley Hospital, Toronto, Can.

- Galley, Ida M. R. N. Supt., Memorial Hospital, Johnstown, Pa.
 Gallagher, Jas. J. Supt., City Hospital, Jersey City, N. J.
 Garabrandt, Dr. C. Supt., 19 N. Penn. Ave., Atlantic City, N. J.
 Garfield, Elizabeth A. Supt., Reading Hospital, Reading, Pa.
 Garshore, W. M. Trustee, Victoria Hospital, London, Canada
 Gask, Harriet Supt., Director of Social Service, Milwaukee Children's Hospital, Milwaukee, Wis.
 Geffen, Joseph Supt., Mt. Sinai Hospital, Philadelphia, Pa.
 Genevieve, Sister M. Supt., St. Elizabeth's Hospital, Youngstown, O.
 Georgiana, Sister M. Supt., St. Arnes Hospital, Philadelphia, Pa.
 Geraldine, Sister M. Asst. Supt., St. Elizabeth's Hospital, Youngstown, O.
 Gibson, Mrs. Gertrude W. Supt., Prospect Heights Hospital, Brooklyn, N. Y.
 Geraghty, W. M. Dietitian, New Haven Hospital, New Haven, Conn.
 Gwyer, Dr. Frederick Supt., Lincoln Hospital, New York City
 Gill, Chas. A. Supt., Germantown Hospital, Germantown, Philadelphia, Pa.
 Gilmore, E. J. Supt., Wesley Memorial Hospital, Chicago, Ill.
 *Goodwin, Chas. W. M. D. Supt., Staten Island Hospital, Tomkinsville, S. I., N. Y.
 *Good, N. W. Supt., Protestant Hospital, Columbus, O.
 Goodwin, H. C. Supt., Albany Hospital, Albany, N. Y.
 Gages, Alice Marie J. N. Norton Memorial Infirmary, Louisville, Ky.
 Graham, W. T. M. D. Supt., University Hospital, Iowa City, Iowa
 Green, Frederick R. General Secretary, United Hospital Fund of N. Y., New York
 Griffin, Rev. Maurice F. Trustee, St. Elizabeth's Hospital, Youngstown, O.
 Graves, Lulu Pres., American Dietetic Association, 58 E. Washington St., Chicago, Ill.
 Grimshaw, Chas. R. Supt., Roosevelt Hospital, New York City
 Greener, Elizabeth A. Supt., of Nurses, Mt. Sinai Hospital, New York
 Guenther, Leopoldine Supt., Supervisor of Nurses, Philadelphia Hospital for Contagious Diseases, Philadelphia, Pa.
 Gutwale Kathryn R. Supt., Mercy Hospital, Columbus, O.
 Happel, Mary E. 57 Leonard St., New York City
 Haworth, Jno. Supt., St. John's Riverside Hospital, Yonkers, N. Y.
 Hagan, Mrs. Bessie A. 156 5th St., New York City
 Hamel, Mrs. H. Supt., Memorial Hospital, Mt. Pleasant, Pa.
 Higbee, Eliz. A. Hackensack Hospital, Hackensack, N. J.
 Hornsby, Dr. Charles Supt., St. John's Riverside Hospital, Yonkers, N. Y.
 *Haddon, George Sec., Vancouver General Hospital, Vancouver, B. C.
 Hamer, Laura M. Supt., Mercy Hospital, Altoona, Pa.
 Hanes, Miss Harriet Supt., Barnabas Hospital, Minneapolis, Minn.
 Hall, Nathan P. Supt., Franklin Hospital, Philadelphia, Pa.
 Hamilton, Dr. Stewart Supt., Harper Hospital, Detroit, Mich.
 Hamilton, Mrs. Jos. B. Supt., Somerset Hospital, Somerville, N. J.
 Happerett, C. R. N. Supt., Rushwick Hospital, Lock Haven, Pa.
 Haworth, E. P. Supt., William Maternity Sanatorium, Merger Grace Hospital, Kansas City, Mo.
 *Haws, Mary E. Supt., Hahnemann Hospital, Scranton, Pa.
 Haynes, Jean G. N. Supt., Rushwick Hospital, Lock Haven, Pa.
 Hayden, Mrs. Sarah Supt., Augusta General Hospital, Augusta, Me.
 Hayes, Mary A. Asst. Supt., University of Pennsylvania Hospital, Philadelphia, Pa.
 Hays, Dr. M. J. Supt., Kane Summit Hospital, Kane, Pa.
 Haywood, A. K. M. D. Supt., Montreal General Hospital, Montreal, Quebec
 Heiden, Henry Supt., General Public Hospital, St. John, N. B.
 *Hancker, Wm. H. M. D. Med. Supt., Delaware State Hospital, Farnhurst, Del.
 Henderson, Miss B. M. Supt., Children's Memorial Hospital, Chicago, Ill.
 Herman, Sister Mary Supt., St. Joseph's Hospital, Lancaster, Pa.
 Herrmann, Mary R. Supt., Perth Amboy City Hospital, Perth Amboy, N. J.
 Hevessy, Berthold Supt., Jewish Hospital, Philadelphia, Pa.
 Heimer, W. H. M. D. Supt., Park Place Hospital, Pawtucket, R. I.
 Hewes, Albert S. L. Supt. and Treas., West Philadelphia General Homeopathic Hospital, Philadelphia, Pa.
 Highsmith, D. J. Supt., Ochsner and Surgeon, Highsmith Hospital, Fayetteville, N. C.
 Hill, Caroline, R. N. Supt., Mary McClellan Hospital, Cambridge, N. Y.
 Hilda, Sister M. Supt., New Castle Hospital, New Castle, Pa.
 Hildreth, C. B. Supt., St. Luke's Hospital, Cleveland, O.
 Hilker, F. C. Supt., St. John's Riverside Hospital, Yonkers, N. Y.
 Hill, Miss M. Supt., West Side Hospital, Scranton, Pa.
 Hill, C. D. M. D. Supt., Watts Hospital, West Durham, N. C.
 Hill, Dr. H. Philip Supt., Robt. B. Green Memorial Hospital, San Antonio, Tex.
 Hofstet, Miss Astrid R. N. Supt. of Nurses and Asst. Supt. Methodist Hospital, Omaha, Neb.
 Holt, E. E. Supt., Eye and Ear Hospital, Portland, Me.
 Hortense, Sister M. Supt., St. Elizabeth's Hospital, Youngstown, O.
 Hornbeck, S. H. Physicians' and Surgeons' Hospital, Corsicana, Tex.
 Howard, J. R. Supt., New York Orthopedic Hospital, N. Y. City
 Howland, Joseph R. Supt., Massachusetts General Hospital, Boston, Mass.
 Hunt, A. C. Supt., State Department of Health, Trenton, N. J.
 Hunt, Nellie E. Supt., Ellwood City Hospital, Ellwood City, Pa.
 Hurd, Henry M. Supt., John Hopkins Hospital, Baltimore, Md.
 Huth, F. C. M. D. Supt., Surgeon of Cambridge Hospital, Cambridge, O.
 Innocent, Sr. M. Supt., Mercy Hospital, Pittsburgh, Pa.
 Ivory, Margaret A. Supt., Windber Hospital, Windber, Pa.
 Jamieson, May A. Supt., Grant Hospital, Columbus, O.
 Johnson, T. M. Supt., Frederick, Md.
 Johnson, Jane Supt., Bradford Hospital, Bradford, Pa.
 Jennings, Miss V. M. Supt., St. Luke's Hospital, San Francisco, Cal.
 Johanna, Mother M. Supt., Danville, N. Y.
 Jackson, Mary C. Supt., W. C. Graham Hospital, Keokuk, Iowa
 *Jarrett, Miss Mary Supt., Psychopathic Hospital, Boston, Mass.
 Jeffrey, Annie C. Supt., St. Christopher's Hospital, Philadelphia, Pa.
 Jones, Sr. Mary Supt., St. Joseph's Hospital, Lancaster, Pa.
 Johnston, M. L. Supt., Rochester Homeopathic Hospital, Rochester, N. Y.
 Jones, Frank R. Supt., Willard Parker Hospital, New York City
 Jones, William M. Supt., Bridgeport Hospital, Bridgeport, Conn.
 Jones, Mary Moore Supt., Children's Episcopal Hospital, Cincinnati, O.
 *Joseph, Hannah L. Supt., Head Worker, N. Y. Hospital, New York City
 *Judge, James P. Supt., St. Peter's Hospital, Brooklyn, N. Y.
 *Kandel, Phoebe Miller Supt., Springfield City Hospital, Springfield, O.
 Karp, T. J. Supt., Colonial Hospital, Rochester, Minn.
 *Karrakis, Joseph Supt., Beth Israel Hospital, Newark, N. J.
 Kelley, E. A. R. N. Supt., Highsmith Hospital, Fayetteville, N. C.
 Keller, Lydia H. R. N. Sec. and Treas., Minnesota State Hospital, St. Paul, Minn.
 Keith, Mary L. Supt., Rochester General Hospital, Rochester, N. Y.
 *Kent, E. M. Violet Supt., Overlook Hospital, Summit, N. J.
 Kienle, Rev. G. A. Supt., General Hospital, Mansfield, O.
 Knight, Mrs. S. H. Supt., E. Deaconess' Hospital and Home, Minneapolis, Minn.
 Korndorfer, A. Med. Dir., Children's Homeopathic Hospital, Philadelphia, Pa.
 Knapp, Macie N. Supt., Overlook Hospital, Summit, N. J.
 Krusen, Dr. E. A. Supt., Riverside Private Hospital, Norristown, Pa.
 Kurtz, Ida M. Supt., Northwestern General Hospital, Philadelphia, Pa.
 Laughlin, Anna E. Supt., Bryn Mawr Hospital, Bryn Mawr, Pa.
 Lent, Mary E. Supt., U. S. P. H. S., Washington, D. C.
 Lockwood, Miss Mary L. 602 West St., Wilmington, Del.
 Ludovica, Sister M. Supt., Danville, N. Y.
 Lynch, Albert Supt., Fairbury, Neb.
 *Lund, Miss S. Supt., Good Samaritan Hospital, Sandusky, O.
 Landis, Maude Supt., New Haven Hospital, New Haven, Conn.
 Langrill, Dr. W. F. Supt., Hamilton City Hospital, Hamilton, Can.
 *Lawler, Dr. J. M. Supt., Allegheny General Hospital, Pittsburgh, Pa.
 Lawson, M. A. Supt., City Hospital, Akron, O.
 Lake, Amzi Supt., Masonic Home, Burlington, N. J.
 *Larkin, Theodore Supt., Vermont Hospital, Mt. Vernon, N. Y.
 Leonard, J. E. Supt., Leonard's Sanitarium, Atlantic City, N. J.
 *Leppert, Louisa M. Supt., Theda Clark Hospital, Seneca, Wis.
 Lewis, Edwin R. Supt., Hahnemann Hospital, Rochester, N. Y.
 Littlefield, Julia A. Supt., Homeopathic Hospital, Albany, N. Y.
 Locke, Dr. H. L. F. Supt., Hartford Isolation Hospital, Hartford, Conn.
 Loder, Cornelius S. 30 Hurst St., New York.
 Loveland, F. A. Supt., Corry, Pa.
 Ludewig, F. Virginia Supt., Atlantic City Hospital, Atlantic City, N. J.
 Lurkins, Frances L. Supt., Laura Franklin Free Hospital for Children, New York
 Lyons, Barrow B. Supt., Delaware Hospital, Wilmington, Del.
 MacEachern, Malcolm T. M. D. Supt., General Supt., Vancouver General Hospital, Vancouver, B. C.
 MacGarry, Mary C. Supt., Charter Oak Hospital, Hartford, Conn.
 *MacKay, Alex. M. D. Inspector of Hospitals, Province of Ontario, Toronto, Ont.
 MacLeod, Dr. Norman M. Supt., Newport Hospital, Newport, R. I.
 McNichols, C. E. Supt., St. Peter's Hospital, Charlotte, N. C.
 McMillan, Dr. W. A. Supt., McMillan Hospital, Charleston, W. Va.
 Manley, Florence H. R. Supt., Presbyterian Hospital, Charlotte, N. C.
 *Manley, Florence H. R. Supt., Niagara Falls Memorial Hospital, Niagara Falls, N. Y.
 Marcella, Sister M. Supt., Sister of Charity, Directress of Nurses, Pittsburgh Hospital, Pittsburgh, Pa.
 *Mary Dolores, Sister Supt., St. Catherine's Hospital, Brooklyn, N. Y.
 *Mary Eugenia, Sister Supt., Mary Immaculate Hospital Association.
 Matthews, Elmer E. Supt., Wilkes-Barre City Hospital, Wilkes-Barre, Pa.
 Matthews, Frances C. Supt., New Samaritan Hospital, Sioux City, Ia.
 Mauss, Bessie W. Supt., General Hospital, Wellsville, N. Y.
 Maxwell, Anna C. Supt., Presbyterian Hospital, New York City.
 McArthur, Miss E. J. Supt., General Hospital, Stratford, Ont.
 *McCreight, M. Emily Supt., Arnot Orden Hospital, Elmira, N. Y.
 McDermid, Grace D. R. N. Supt., Hackley Hospital, Muskegon, Mich.
 McEwen, Rachel Supt., Malden Hospital, Mury Hill Road, Malden, Mass.
 McLaren, Margaret Supt., Warren General Hospital, Warren, Pa.
 McKee, Gertrude Supt., Milwaukee Children's Hospital, Milwaukee, Wis.
 McLeod, Josephine Supt., Johnston-Willis Hospital, Richmond, Va.
 *Melo, Dr. Carl Supt., Grace Hospital, Detroit, Mich.
 Mauroid, Louis Supt., Wauwatosa, Wis.
 McNichols, Emma V. Supt., Charlotte, N. C.
 Mann, D. B. Supt., Williamsport Hospital, Williamsport, Pa.
 McMahon, Mary Supt., St. Joseph's Hospital, Omaha, Neb.
 Marshall, George Morley, Dr., Philadelphia, Pa.
 Miner, G. S. Dr., Trustee Receiving Hospital, Detroit, Mich.
 Morrow Joseph R. Mrs. Oradell, N. Y.
 *Morton, Sister M. Supt., St. Joseph's Hospital, Baltimore, Md.
 *Markes, Ediz. G. Mrs. Supt., St. Joseph's Hospital, Chicago, Ill.
 Mathison, Wm. R. Supt., Briardale Hospital, Toronto, Canada.
 Metcalfe, Rachel A. Supt., Central Maine General Hospital, Lewiston, Me.
 Middleton, Miss Mary A. Supt., Methodist Episcopal Hospital, Philadelphia, Pa.
 Minahan, Elizabeth Supt., Wilford Hospital, Augusta, Ga.

- *Mindte, Anna C. Supt. of Nurses, Memorial Hospital, New York City.
- Miller, Elizabeth. Supt., Dover General Hospital, Dover, N. J.
- Miller, Elizabeth F. University of Pennsylvania, Philadelphia, Pa.
- Millman, Miss Elizabeth. Supt., Orange Memorial Hospital, Orange, N. J.
- *Morley, Miss Rye. Supt., New York Nursery & Children's Hospital, New York City.
- Moyer, Katharine A. Supt., Pottstown Hospital, Pottstown, Pa.
- *Moody, Earle F. Pres., Moody Hospital, Dothan, Ala.
- Moore, Lucy M. Supt., Knickerbocker Hospital, New York City.
- Moore, Frances W. Supt., Sibley Hospital, Washington, D. C.
- Moore, Helen de Spelder. Supt., W. A. Foote Memorial Hospital, Jackson, Mich.
- Morris, Anna L. Supt., White Haven Sanatorium, White Haven, Pa.
- Morris, C. C. Supt., Baptist Hospital, St. Louis, Mo.
- Morrow, Joseph R. Supt., Isolation Hospital, Berzen Co., Oran, N. J.
- Morgan, Dr. Esther. Supt., Dixie Hospital, Hampton, Va.
- Moss, H. J., M. D. Supt., Hebrew Hospital, Baltimore, Md.
- Mossell, M. S. Supt., Douglass Hospital, Philadelphia, Pa.
- Mockershead, Pearl A. Supt., Ottumwa Hospital, Ottumwa, Iowa.
- Mueller, Mrs. Margaret. Supt., Greenville Hospital, Jersey City, N. J.
- *Munger, C. W. Supt., Columbia Hospital, Milwaukee, Wis.
- Monroe, J. P. Charlotte Sanatorium, Charlotte, N. C.
- Murphy, Addie L. Supt., Materinity & Children's Hospital, Toledo, O.
- *Murray, E. W. Med. Dir., Babies' Hospital, Newark, N. J.
- Musgrave, Dr. W. E. Univ. of California Hospital, San Francisco, Cal.
- Myers, J. O. Med. Dir., Tranquil Park Sanitarium, Charlotte, N. C.
- Nagle, A. F., Jr. Modern Hospital, New York City.
- Narr, Fred C., Dr. Pathologist Passavant Hospital, Pittsburgh, Pa.
- Nassau, Sarah. Bethel Sisterhood Supt., 57 E. 86th St., New York City.
- Nealey, Dr. W. G. Supt., Brooklyn Hospital, Brooklyn, N. Y.
- Nevas, George. Dir. of Nurses, Potomac Division, Washington, D. C.
- Newman, W. M. Supt., Sewickley Valley Hospital, Sewickley, Pa.
- *Neumer, Howard E. Supt., Luke's Hospital, Bethlehem, Pa.
- Norris, John U. Acting Supt., Presbyterian Hospital, New York City.
- Oberz, C. L. Supt., Sherman Hospital, Elgin, Ill.
- O'Hara, Margaret G. Directress, Dermady Cottage Sanatorium, Morton, Pa.
- Olsen, E. Supt., Englewood Hospital, Chicago, Ill.
- Owen, Elizabeth M. Highsmith Hospital, Fayetteville, N. C.
- Page, H. F. Med. Supt., Lankman Hospital, Philadelphia, Pa.
- Parker, H. E. Supt., Kensington Hospital, Philadelphia, Pa.
- Parnall, C. G. Dir. University Hospital, Ann Arbor, Mich.
- Patrick, T. A. Supt., Lincoln Co. Hospital, Fayetteville, Tenn.
- *Perry, Miss Charlotte M. Supt., Paxton Hospital, Utica, N. Y.
- Peters, J. M. Supt., R. I. Hospital, Providence, R. I.
- Phillips, G. E. Supt., Herman Kiefer Hospital, Detroit, Mich.
- Pine, Emily. Supt., R. S. Frost Hospital, Chelsea, Mass.
- Pinkerton, Elizabeth. Supt., Nyack Hospital, Nyack, N. Y.
- Pitcher, C. S. Kings Park San., Kings Park, N. Y.
- Pollock, Helen M. Instructor, Grace Hospital, Detroit, Mich.
- Powell, L. M. Acting Supt., University Hospital, Minneapolis, Minn.
- Pond, E. L. Brooklyn Hospital, Brooklyn, N. Y.
- *Potter, Ellen C. Cottage Hospital, Philadelphia, Pa.
- Potter, E. C. Med. Dir., Medical College of Pennsylvania, Philadelphia, Pa.
- Potts, F. J. Supt., Hospital for Sick Children, Toronto, Can.
- Putts, Mary J. Supt., Kings' Daughters' Hospital, Temple, Tex.
- Purvis, Joseph. Supt., West Suburban Hospital, Oak Park, Ill.
- Price, Dr. G. M. Union San., New York City.
- Qualoni, Friedman. Mount Sinai Hospital, Cleveland, Ohio.
- Ramson, Mildred L. 57 Leonard St., New York City.
- Read, C. O. Pres. Board of Trustees, Pawtucket Memorial Hospital, Pawtucket, R. I.
- Reardon, E. A. Supt., Ohio Valley Hospital, McKees Rocks, Pa.
- Redwine, Miss E. M. Supt., Meriwether Hospital, Asheville, N. C.
- Richardson, Dr. Katherine B. Children's Mercy Hospital, Kansas City, Mo.
- Ricketts, H. E. Supt., Bellevue Hospital, Bellevue, N. J.
- *Rita, Sister Mary. Supt., Mercy Hospital, Chicago, Ill.
- Robins, Charles B. Richmond, Va.
- Rose, Mrs. Summer A. Homeopathic Hospital, New York.
- Rockins, Sister M. Supt., Jewish Hospital, Baltimore, Md.
- Roberts, Catherine E. Johnstown, Pa.
- Rosalinde, O. S. D. St. Catherine's Hospital, Brooklyn, N. Y.
- Romans, Sister M. Supt., St. Joseph's Hospital, Kansas City, Mo.
- Rogers, Margaret. Supt., Jewish Hospital, St. Louis, Mo.
- *Rogers, Margaret A. Supt., Children's Free Hospital, Detroit, Mich.
- Roche, Frances E. Asst. Supt., Litchfield County Hospital, Windsted, Conn.
- Robertson, Marie. Deaconess Hospital, Buffalo, N. Y.
- Robertson, Donald M. Supt., Protestant Hospital, Ottawa, Can.
- Rothrock, Anna E. Supt., Fall River, Mass.
- Riley, Ella S. St. Francis Hospital, San Francisco, Cal.
- Rushmore, Stephen, Dr. Carney Hospital, Boston, Mass.
- Russell, C. M. Massillon Hospital, Massillon, Ohio.
- *Russell, May M. Jewish Hospital, Cincinnati, O.
- Schmabel, Eliz. H. Division of American Red Cross, Philadelphia, Pa.
- Shancher, R. H. St. John's Hospital, Yonkers, N. Y.
- Singer, Douglas H. Dept. of Public Welfare, Kankakee, Ill.
- *Shaeffer, Susan V. Supt., Easton Hospital, Easton, Pa.
- *Saffier, Rosa A. Supt., The Jamaica Hospital, New York City.
- de Sales, Sister M. St. Joseph's Hospital.
- Saunders, Sister M. St. Francis Hospital, Pittsburgh, Pa.
- *Sauer, G. M. Supt., Lennox Hill Hospital, New York City.
- Schill, Anna M. Supt., Hurley Hospital, Flint, Mich.
- *Schneider, Miss P. J. C. Blair Memorial Hospital, Huntington, Pa.
- Schulz, F. M. Wauwatosa, Wis.
- Schwab, Barbara. Jewish Hospital, Philadelphia, Pa.
- Schwab, David. Supt., Barnett Memorial Hospital, Paterson, N. J.
- Scott, Kathleen. Supt., Sparrow Hospital, Lansing, Mich.
- Seabrook, Alice. Supt., Woman's Hospital, Philadelphia, Pa.
- Seem, Dr. R. P. Johns Hopkins Hospital, Baltimore, Md.
- Selby, Nelle M. Memorial Hospital, Pawtucket Hospital, Pawtucket, R. I.
- *Seymour, Adeline. Supt., Samaritan Hospital, Detroit, Mich.
- Sexton, L. A. Supt., Hartford Hospital, Hartford, Conn.
- Shaw, J. M. Supt., Hospital for Women and Children, Newark, N. J.
- Smith, A. W. Supt., Garfield Hospital, Washington, D. C.
- Smith, J. N. Supt., Muhlenberg Hospital, Plainfield, N. J.
- Smith, Nina A. Lancaster General Hospital, Lancaster, Pa.
- Smylie, Margaret S. Supt., St. Timothy's Hospital, Philadelphia, Pa.
- Stanislaus, Sister Mary. St. Mary's Hospital, Clarksburg, W. Va.
- Steinmetz, Rose. Supt., Children's Hospital, Akron, O.
- Stevens, E. F. Boston, Mass.
- Stewart, Annabel L. Women's Southern Homeopathic Hospital of Philadelphia, Philadelphia, Pa.
- Stokes, L. W. Supt., Women's Southern Homeopathic Hospital of Philadelphia, Philadelphia, Pa.
- Stone, Mary. Supt., Hackensack Hospital, Hackensack, N. J.
- Strasser, C. E. Supt., Jewish Hospital, Brooklyn, N. Y.
- Sutbray, Mary E. Supt., Corning Hospital, Corning, N. Y.
- *Smith, Emma Margaret. Corning Hospital, Corning, N. Y.
- Stewart, Chas. E. Asst. Supt., Battle Creek Sanitarium, Battle Creek, Mich.
- Stafford, S. W. Charity Hospital, New Orleans, La.
- Smith, Marion. Supt., University Hospital, Philadelphia, Pa.
- Schafer, Esther E. Acting Supt., Chester County Hospital, W. Chester, Pa.
- Smith, Theresa Marie. Supt., Stormont Hospital, Topeka, Kan.
- Shardon, Wm., Dr. 531 E. 86th St., New York City.
- Summer, Mrs. A. W. President, Women's Southern Homeopathic Hospital, Philadelphia, Pa.
- Tall, Anthony. Supt., Buffalo Homeopathic Hospital, Buffalo, N. Y.
- Targart, Thomas D. Atlantic City, N. J.
- Talbot, C. E. Supt., Newark Hospital, Newark, N. J.
- Tebbets, Marian A. Minneapolis, Minn.
- Test, D. D. Pennsylvania Hospital, Philadelphia, Pa.
- Templeton, Nelle I. Supt., Salem City Hospital, Salem, O.
- Tarpin, Mary B. Supt., Erie and Erie Hospital, Pittsburgh, Pa.
- *Thompson, Florence M. Supt., St. Luke's Hospital, Davenport, Iowa.
- Thatcher, Alice. Supt., Christ Hospital, Cincinnati, O.
- Tipping, A. B. New Orleans, La.
- Toll, Henry W. Navy Building, Washington, D. C.
- Tinsley, Esther J. Supt., Pittston Hospital, Pittston, Pa.
- Turner, Alida. Supt., Homeopathic Hospital, Wilmington, Del.
- Tuley, H. E. Supt., Louisville City Hospital, Louisville, Ky.
- Thornton, Janet. Boston Dispensary, Boston, Mass.
- Toland, M. C. Babies' Hospital, Dispensary, Philadelphia, Pa.
- Van Vort, Rose Z. Supt., Stuart Circle Hospital, Richmond, Va.
- Viehdoerfer, Alma M. Supt., Allentown Hospital, Allentown, Pa.
- *Vidt, John C. Newark City Hospital, Newark, N. J.
- Van Slyke, Elizabeth. Dr. Women's Hospital, New York City.
- Vaughan, Mrs. E. E. Chicago Union Hospital, Chicago, Ill.
- Virginia, Sister M. Repre. Sister M. Elenore, Marshfield, Wis.
- Wadley, Mary E. Bellevue Hospital, New York City.
- Walker, Eugene, Dr. Asst. Supt., Massachusetts Charity Eye and Ear Hospital, Boston, Mass.
- Warner, A. R. Lakeside Hospital, Cleveland, O.
- Washburne, Ida. Supt., Eastern Maine General Hospital, Bangor, Me.
- *Watson, William. Essex County Hospital, Belleville, N. J.
- Watson, Elizabeth. Supt., Philadelphia Hospital for Women, Philadelphia, Pa.
- Weber, Gertrude T. Olney Sanitarium, Olney, Ill.
- Weber, Joseph. The Modern Hospital, Boston, Mass.
- Weber, F. Supt., Evangelical Deaconess Hospital, Chicago, Ill.
- Webster, H. E. Supt., Royal Victoria Hospital, Montreal, Can.
- *West, George, M. D. West Ellis Hospital, Chattanooga, Tenn.
- Wise, Dr. E. A. Mercy Hospital, Pittsburgh, Pa.
- West, Robert M. Philadelphia, Pa.
- *West Ellis Hospital. Chattanooga, Tenn.
- White, A. J., M. D. Boston Consumptive Hospital, Boston, Mass.
- Whiting, Dr. A. D. Med. Dir., Germantown Hospital, Philadelphia, Pa.
- Williams, H. C., M. D. St. Island, New York City.
- Williams, Dr. I. D. Supt., C. B. Towns Hospital, New York City.
- Wilson, Margaret L. Supt., Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases, Philadelphia, Pa.
- Wise, Helen V. University Hospital, Baltimore, Md.
- Walker, John W. Trinity Mission Hospital, Winner, S. D.
- Welden, Mrs. E. Wesley Homeopathic Hospital, Wilmington, Del.
- Weeks, David F. N. J. State Hospital for Epileptics, Skillman, N. J.
- Wharton, Bromley. Secy., Board of Public Charities, Philadelphia, Pa.

Whitney, Mary J.	Supt., Ware Hospital, Worcester, Mass.	Woodside, Margaret N.	Supt., Braddock General Hospital, Braddock, Pa.
Willis, Edith T.	Supt., Good Samaritan Hospital, Vincennes, Ind.	Worth, Collen M.	Supt., Trenton Memorial Hospital, Trenton, N. J.
Wilkes, P. C.	Supt., Baptist Memorial Hospital, Memphis, Tenn.	Wright, W. E.	Acting Supt., Burke Foundation, White Plains, N. Y.
Wehmet, F. L.	State of Nebraska.	Wright, Mrs. Lucia M.	Supt., Homeopathic Hospital, Reading, Pa.
Wilson, Martha	Pres., Auxiliary Board Children's Hospital, Chicago, Ill.	Wright, Ethel.	S. S. Dept., St. Christopher Hospital.
Wilson, R. J.	Dir., Board of Hospital, Dept. of Health, New York City.	Xavier, Sister Mary	Supt., St. Joseph's Hospital, Reading, Pa.
Wilson, Geo. S.	Secy., Board of Charities, Dist. Bldg., Washington, D. C.	Yearick, H. G.	Supt., St. Luke's Hospital, Spokane, Wash.
Wolecott, Miss Grace L.	Supt., Waterbury Hospital, Waterbury, Conn.	Yinist, Edith	Supt., Carlisle Hospital, Carlisle, Pa.
Wood, Kathryn W.	Directress, Burke Foundation, White Plains, N. Y.	*Young, Dr. C. S.	Washington Park Hospital, Chicago, Ill.

PAPERS AND REPORTS PRESENTED AT ATLANTIC CITY MEETING

Reports Show Gratifying Progress of Association—Papers Indicate That Grave Hospital and Nursing Problems Presented by War are Well in Hand

The War and the Civil Hospitals

By ARTHUR B. ANCKER M.D., President American Hospital Association, Superintendent St. Paul City and County Hospital, St. Paul, Minn.

The American Hospital Association, assembled at this twentieth annual convention, finds humanity passing through a crucial period. All the world is at war. When we met, one year past, a few months after the war declaration, the country was slowly but effectively mobilizing its resources. Today America has become a mighty factor in the great struggle for freedom. Nothing else matters now but winning the war. To this cause America is dedicated—its spirit and its might. To this cause we here must contribute. The civil hospitals have at all times and especially now an important field of work. This work must be done and done well.

The great war has brought the civil hospitals of America face to face with serious problems. To the end that the health of our Army shall be safeguarded, civil hospitals have given willingly of their clinical and nursing staffs. They must give more and still more. The continued call for nurses for home and foreign service is fast reducing the graduate nursing personnel of the hospitals. The civil hospitals will have an important part in the providing and training of future medical officers and nurses. At the same time they must make adequate provision for the hospital care of the civil population. The part the civil hospitals are to take in the reconstruction and rehabilitation is as yet undetermined. The whole problem is difficult. The adoption of a comprehensive, cooperative program is imperative.

The civil hospitals have unhesitatingly accepted calls for war service. They expect further calls of various kinds. Official announcement has been made, however, by the Surgeon General of the Army that civil hospitals will not be used for the present by this Department for the care of returned soldiers. Limited use is now being made for this purpose of certain civil hospitals. The extension and development of existing civil hospitals under government direction has been advocated as a necessary policy instead of the present plan of using converted army posts and Federal hospitals and also the building and equipping of special military hospitals. The former would seem to be consistent with economy and with efficiency of service to both the military and civil population. It would not result in the complete breaking up of the clinical and nursing organizations of the civil hospitals. It should cost less than for independent construction and new equipment. These policies are worthy of careful consideration by this convention. Wise statesmanship will prompt those representing the civil hospitals, individually and collect-

ively, to anticipate that the Government will later make a wider use of civil hospitals for returned soldiers. If the war continues long, necessity will compel such action. It is our obvious duty to help the War Department foresee these hospital war needs, as well as the needs of the civil population, and to plan to meet them constructively. If we so fail, we shall be "weighed in the balance and found wanting."

We are met here now to discuss and deliberate upon these hospital problems of today. They are not alone individual problems, but the hospital and health problems of the nation at war. There are wide differences of opinion concerning the merits of the numerous hospital medical and nursing programs designed to meet these rapidly increasing problems. Vital issues have been raised. They must not only be discussed here but settled. To this end concerted action is imperative. Representatives of several important Federal departments are to take part in our program. Representatives of the Surgeon General's office will discuss certain hospital war problems especially in their relation to civil hospitals. They will be expected to answer questions. They should tell us of the hospital and nursing programs of the army and, above all, what further calls for war service will be made upon the civil hospitals. The civil hospitals have a right to know.

The great crisis has not found the American Hospital Association unmindful of its responsibilities. Its War Service Committee has been most active. Mr. Richard P. Borden, secretary of the committee, has been regularly in Washington at least three days a week. The report of this committee is commended to your careful attention. It emphasizes our added war obligations. Some of the hospital problems confronting this committee, as well as those confronting the Legislative Committee, have been made known to you from time to time through special bulletins, and your advice and assistance solicited. The president urges your favorable consideration of the recommendations of these two committees. By all means definite action should be taken on the proposed Federal Inheritance Tax in its relation to hospitals as recommended by the Legislative Committee.

The American Hospital Association has for many years been a voluntary personal association of hospital people. As such, it has prospered and rendered helpful public service. There has been a growing feeling, however, that the Association should develop along broader lines and that for this purpose the adoption of a plan of reorganization is necessary. From time to time it has been suggested that this Association should become an Association of American Hospitals. The war has produced added reasons in support of this proposal. Accordingly, at the last

meeting of the trustees, the president was authorized to appoint a special committee to consider and report on this question. The committee has reported. Its report has been placed in the hands of every member of the association. It cannot fail of adoption.

Your president urges the adoption of this proposal for reorganization as it stands—not only because it will help to make possible “an association of American hospitals to promote the welfare of American hospitals and to protect the interests of hospitals and hospital work”; not only because it will mean more effective war service organization; but because it paves the way for real effective hospital standardization. Experience of over thirty years in active hospital work compels me to assert with all the strength I have that standardization and classification of hospitals must and will come directly from the initiative of the hospitals themselves. Standardization of hospitals now on any basis except as affected by the war is useless. Yet the American Hospital Association may well now attempt a beginning in this direction through “the simple yet effective standardization from election to membership.” It is the honor of a life-time to be here today and recommend, as your president, the adoption of this report, knowing full well, as I do, that in the progressive development of the American Hospital Association it will mark an historic milestone.

Let us proceed then to our program. Let us be temperate in our debate and constructive in our criticism and concerted action. Let us so conduct ourselves on this historic occasion that it may be said with all truth that the twentieth annual convention of the American Hospital Association was a real demonstration of the power of the organized hospitals of America to think and to plan constructively in terms of the present great crisis and for the future.

Resolutions Presented by the Resolutions Committee

CONTROL OF VENEREAL DISEASE

Resolved, That the American Hospital Association heartily endorses the program of the War Department for the control and treatment of venereal disease, and that the hospitals of the country be urged to cooperate with this program in every way, and particularly, by developing, or when necessary establishing, clinics for treating venereal disease, and by opening their wards to patients with these diseases who require bed care; and be it further

Resolved, That the Committee on Out-Patient Work be authorized and directed to prepare a suitable statement incorporating this resolution, to be sent, after approval by the president of the association, to the proper officials of the hospitals of the country.

HOSPITAL ASSISTANTS

At a conference recently held in Washington it was

Resolved, That civil hospitals which have the necessary facilities be encouraged to arrange for the training and use of hospital assistants according to the plans and qualifications of the Army School of Nursing. Such hospital assistants should be enrolled through the American Red Cross with the understanding that they will accept service as required either—(1) With the hospitals in which they are trained; (2) with the American Red Cross; or (3) in army hospitals.

Inasmuch as the foregoing recommendations involve a plan of action which implies the cooperation of the civil hospitals, the Red Cross and the Medical Department of the army, the American Hospital Association requests an early conference with the other parties concerned for the purpose of arriving at a complete working understanding of all the details of the proposed agreement.

Resolved, That the association hereby records its hearty approval of the principle of the proposed cooperative scheme and urges its members to participate in every possible way.

GRADUATE MEDICAL STUDENTS

The American Hospital Association desires to emphasize the necessity, for both civil and military reasons, of continuing the established method of providing post graduate clinical training in the civil hospitals for the graduates of medical schools.

Under laws and regulations recently enacted, the assignment of graduate medical students to hospitals and the conditions of such assignments rests entirely with the military authorities.

Resolved, That a committee of seven members, representative of various types of hospitals, be appointed by the president for the purpose of promoting a proper solution of the educational, military, financial and administrative problems which are bound up with this question and that such committee be empowered to represent this association in negotiations with the War Department.

Resolved, That the president of the association shall be ex-officio member of this committee.

HOSPITAL EMPLOYEES

Resolved, That this association greatly appreciates the concern which the Acting Secretary of War has shown in the difficulty of hospitals with regard to employees, and, in accordance with his expressed wish, makes the following suggestion—viz.: that all male employees of hospitals shall, upon request of hospitals to the draft boards, be exempt from military duty during the period of hospital employment, this to include engineers, firemen, orderlies, porters, chiefs, pharmacists, laboratory and x-ray technicians, ambulance drivers and chauffeurs, and others especially trained or accustomed to hospital service; it being understood that hospital authorities shall not claim exemption when the work may be done by women or by men incapable of military service and that any institution violating this understanding shall be entitled to no further recognition.

ORGANIZATION OF CIVILIAN PHYSICIANS FOR MILITARY SERVICE

Resolved, That in view of the inevitable difficulty in supplying a sufficient number of physicians to meet the military and civilian requirements and the necessity that certain of the most skillful members of the profession should remain on duty with hospitals, medical schools, public health organizations and to meet other imperative professional requirements, it is the sense of this association that some organization should be perfected whereby such physicians may be made available, in their several communities, to care for returned soldiers in hospitals in their vicinities.

The association gratefully acknowledges receipt of communication from the Acting Secretary of War which reads in part as follows:

“As to physicians, we are aware of their need in civil as well as military establishments and attention will be given to the fullest possible extent to such measures as may be necessary to safeguard the civil hospitals in this respect.”

Recognizing with the War Department the necessity of such an interpretation of the man-power law as will “not seriously interfere with hospital work or with the care of the public health,” the American Hospital Association records its hearty approval of the instructions to draft boards recently issued by the Provost Marshal General. The association, however, senses a certain danger in the fact that discretionary power in this matter has been entrusted to several thousand boards, whose interpretation of instructions issued from Washington is likely to vary widely and whose interpretations in the mass may, notwithstanding the clearly expressed intention of the Secretary of War and of the Provost Marshal General, take on a form unduly destructive of civil hospital organization or unduly obstructive to the program and needs of the medical department of the army.

The association is unofficially advised that this subject is now receiving the consideration of the authorities at Washington; it urges that steps be taken speedily to insure reasonable uniformity, in the interpretation of the law and the regulations thereunder, reasonable protection to the civil hospitals and due recognition of the military needs. But, while favoring speedy action, the association feels that it is highly important that its representatives should be given an opportunity to be heard on the subject and hereby authorizes the president of the association to take such steps as may be expedient to secure a hearing.

RED CROSS SURVEY

Resolved, That this Association heartily endorses the proposed Survey of the American Red Cross for the purpose of ascertaining the forces available for nursing service in the United States and urges all hospitals and public health organizations, whether represented in this association or not, to aid in every way to secure a rapid and accurate result.

AFFILIATION WITH ARMY TRAINING SCHOOL FOR NURSES

Resolved, That this association fully appreciates the probable value of an army training school for nurses, under such circumstances as will assure to the pupils a complete and adequate professional education, as may undoubtedly be given in such permanent institutions as the Walter Reed and Letterman Hospitals and perhaps under other available opportunities;

That civilian hospitals should cooperate in every way to aid such plan, by affiliation, when it may be of mutual advantage and to the advantage of the pupils concerned, or by any other reasonable method;

That the action of this association should be and is governed, not by a selfish regard for the institutions which it represents, but by an active and sympathetic concern for the men who, by reason of patriotic service, may become patients in army hospitals; and for the pupil nurses, who, from an equally patriotic impulse, may enter the military hospitals;

That, actuated by such motives, the authorities in charge of both the civilian and the military hospitals should give very serious consideration to the problems involved, which include the period in the course of training at which pupils could be exchanged to the advantage of all concerned; the education which the pupil is to receive in the respective institutions; the opportunities for such education; full assurance that the contemplated program may be carried out by both parties to the advantage of the pupils; and a complete understanding and acceptance of the conditions by the students concerned; and that finally, if the above requirements are satisfactorily fulfilled, in the estimation of the institutions concerned, the agreement, if any between the parties, should be set forth in a written contract embodying all the substantial terms and conditions of the engagement.

USE OF EXISTING HOSPITAL FACILITIES

Resolved, That this association most heartily approves the plans of the War Department to provide for the care of our sick and injured soldiers by a most ample provision of hospitals both at home and abroad, and, knowing from experience that the supply of hospital equipment and hospital personnel is very limited, respectfully represents that conservation of both of these essential elements is imperative and suggests and advocates that for this reason existing hospital facilities should be utilized as much as possible by appropriating spaces in hospitals not necessary for civilian requirements for use as military wards, by the temporary construction of such wards in proximity to present hospital building, by arranging for groups of hospitals to accommodate the patients of one of the group so that it may be taken over during the period of the war for military purposes or by such other means as may seem advisable, thus avoiding the unnecessary duplication of administrative and scientific hospital facilities such as operating rooms, laboratories, x-ray apparatus, and the skilled personnel in charge of them.

NURSES IN CAPTIVITY

WHEREAS, The Comptroller of the Treasury has recently ruled that American army nurses held as prisoners of war by an enemy nation are not entitled to pay during captivity, on the ground that, as civilian employees, they are not included in the statute allotting pay to members of the Regular Army, privates, and officers, commissioned and non-commissioned; and

WHEREAS, the army nurse is not a civilian employee but for eighteen years has been by law an integral part of the regular army; therefore be it

Resolved, That the American Hospital Association at Atlantic City in its resolution assembled this 25th day of September requests and urges that the Secretary of War and the Secretary of the Treasury take such steps as may be necessary to remedy this grievous evil.

FEDERAL INHERITANCE TAX BILL

Recognizing that the charitable hospitals of the country, many of which are members of this association, are to a considerable extent dependent upon bequests and endowments with which to carry on their benevolent work, including the work of training increased numbers of nurses for war service, the American Hospital Association desires to go on record officially concerning the provisions of the proposed Federal Inheritance Tax Law, which, if enacted, threatens to inflict an unjust burden upon charitable institutions, including hospitals not operated for private gain; therefore be it

Resolved, That the American Hospital Association, assembled at its twentieth annual convention, earnestly protests the enactment of this provision of the Federal Inheritance Tax Law and lends its entire support to the enactment of the Tax Exemption Bill introduced by Senator Hollis, which is intended to protect the future of hospital endowment and maintenance, and be it further

Resolved, That the Legislative Committee be instructed to make known this attitude of the American Hospital Association to the Finance Committee of the Senate and do everything within its power to persuade said committee to report the bill favorably, and be it further

Resolved, That local hospitals represented at this convention be requested to write their local senators and representatives and urge them to support the Hollis Bill.

Report of the Audit Committee

Your committee was appointed at the session of the convention held on Tuesday, Sept. 24, 1918. No preliminary work had been done prior to this time. The committee discovered many conditions needing attention, but the books have been kept in such a manner that no satisfactory audit can be made at this time. There have been various changes in the personnel of the office, together with a change in the executive secretaryship, so that there seems to have been no complete or definite transfer of in-

structions as to the work required in so far as it relates to the keeping of these accounts.

For the period from January 1, 1918, to August 31, 1918:

Gross income	\$9,807.63
Gross expense	5,827.63
Balance	\$3,980.00

STATEMENT OF RECEIPTS AND EXPENDITURES FROM JANUARY 1, 1918, TO AUGUST 31, 1918

RECEIPTS

Balance in banks Jan. 1, 1918.....	\$4,422.98	
Drawn from Union Trust Co. of Chicago and invested in four Liberty Bonds	400.00	\$4,022.98
Active membership fees.....	\$2,875.07	
Associate membership fees	372.00	
Life membership fee (invested in Liberty Bond).....	50.00	
Commercial exhibits	2,154.51	
Interest on deposits	42.50	
Miscellaneous receipts	280.93	5,784.65
Total receipts		\$9,807.63

EXPENDITURES

Administrative Expenses—		
Office of the president.....	\$ 275.78	
Office of the secretary:		
Salaries	1,450.00	
Supplies	966.64	
Traveling expenses	545.47	
Office equipment	160.48	
Proceedings for 1917.....	1,194.30	
Miscellaneous	91.50	\$4,408.39
Convention Expenses—		
Commercial exhibits	\$ 552.51	
Committee Expenses—		
Committee on war service	465.24	
Committee on out-patient	125.71	599.95
Total expenditures		\$5,827.63
		\$3,980.00

The receipts from life memberships to January 1, 1918, amounted to \$357.29. There have been four memberships since that time, making total to credit of endowment account, \$557.29. Of this amount \$450 has been invested in Liberty Bonds, leaving a balance with the treasurer on September 27, 1918, of \$107.29.

There seems to be a difference in the cash balance between our accounts with the Washington Loan and Trust Company and the Union Trust Company of Chicago, as shown by cash account and that of the bank books, of \$42.93. This difference, however, is not a shortage, as the bank books show this amount in excess over the amount shown by the books of the Association.

SUMMARY OF BALANCES AS FOUND.

Balance Washington Loan and Trust Co., Jan. 1, as per bank book	\$4,172.17
Less checks No. 304 and 307 out—Aug. 22 and 29, 1918.....	57.07
Correct balance as shown	\$4,115.10
Balance as per bank book, Union Trust Co., Chicago.....	357.29
Balance Jan. 1, 1918—all accounts.....	4,472.39
Balance as per cash account.....	4,072.17
Plus balance in Chicago.....	357.29
Total	\$4,429.46
Difference between balance as should be and that shown by cash account and balance in Union Trust Co., Chicago.....	42.93

The Commercial Exhibit account shows deposits equal to the amount entered as cash receipts, but there is no

evidence that the amounts so deposited still remain to the credit of the association.

In the petty cash account from January 1, 1918, to March 1, 1918, no account apparently has been kept of the receipts and expenditures, but this account may have been inactive during that period.

There is no record for the authority of expenditure of money for goods purchased by the association. Purchase order blanks have been prepared for this purpose, but they have not been used.

Throughout all of the records there is a general omission of the dates of receipts and expenditures, so that it is difficult to make a satisfactory audit of accounts.

The plan also required headings for all accounts, but these are omitted in many instances, together with the numbering of the pages.

The Commercial Exhibit account on Sept. 20, 1918, shows a credit of \$4,856.80; of this amount, \$3,666.86 is shown as cash received and a balance still due of \$1,170. The contract with the Commercial Exhibitors calls for a payment of 50 per cent of the amount due ten days from date of contract and the balance on or before August 25, 1918. The time of payment within the specified time has not been enforced.

There is no indication of any misappropriation of any of the funds of the American Hospital Association, but many of the items are incomplete so that it is absolutely impossible to check receipts and expenditures readily, or to balance the books in their present form. The committee is unanimous in believing that the plan itself is able to meet all requirements, but that it has not been maintained in accordance with the original design.

RECOMMENDATIONS.

We recommend that the books of the association be audited and a balance struck as of September 30, 1918, and that the amount then shown be the sum on which all future calculations be based. Then, with the correct use of the plan as previously approved by the board of trustees, and in accordance with the system originally made, there should be no further difficulty experienced.

That the control and direction of financial transactions of the executive office be assumed by the executive secretary. This is the plan adopted by the trustees about one year ago, but it is not now in effect.

That a weekly and monthly financial report be submitted by the executive secretary to the president and treasurer and that a monthly report be submitted to the board of trustees and officers on forms already provided.

That all accounts be closed for the fiscal year on December 31, and that an annual report as of that date be prepared and presented to the board of trustees, accompanied by the bank statements, showing the amount on deposit to the credit of the association.

That a professional audit of accounts of secretary's office and treasurer's accounts be made as of December 31 of each year and at the close of the month previous to the date of convention.

That the present system of accounting be retained and that its provision for showing the financial conditions of the association at all times be used.

That a finance committee of three be appointed, of which the treasurer shall be a member.

That an endowment committee be appointed which shall consist of the board of trustees and the treasurer, which committee shall direct the investment of all moneys from life memberships and gifts to this fund; and that the income from this fund only shall be used for current expenses.

That the rule which provides for a payment by commercial exhibitors of 50 per cent of the fee within ten days after signing contract and payment of the balance be insisted upon prior to the convention.

CORNELIUS S. LODER,
Chairman.
S. J. BARNES,
FRANCIS O. BATES,
ROSA SAFFIER.

Report of the Accounting Committee

The present unsettled state of our hospitals, due to prevailing conditions occasioned through the war, is recognized and appreciated by your Committee on Accounting. They discussed the subject by mail with some of the officers of the association, and they attempted obtaining opinions from various members as to needed improvements of an office, clerical or accounting character. The result was not satisfactory, due to the absence of many of the leaders, and because of the uncertainty in their own minds of those who did respond as to just what it was best to do at the present time.

Those in attendance at the Cleveland Convention last year will recall the committee's making certain concrete, definite recommendations that were unanimously approved. Those who were present may recall the committee's urging you to adopt those suggestions, for we hoped to work out a general scheme which would include some one specific standardization of plan each year until the entire system had been covered. We may well inquire how many returned home and instituted the betterments suggested through this committee.

The American College of Surgeons is in process of collecting data on important hospital problems, and its report promises constructive help. These data are collected by personal visits. And, while the work is still in its beginning, it is already the basis for a series of publications now in preparation. Among them such problems as these are included: What is the responsibility of a Board of Trustees to its hospital? What is a practical working relationship between the trustees and the hospital staff? The hospital superintendent and his relation to the governing board.

The College now has in the form of proof a set of case records in which the aim has been to make them as simple as possible and yet adequate. The experience of the army and of the navy has been utilized in the preparation of these forms, which is a matter of vital importance when we consider that, at the end of the war, some twenty-two thousand doctors will return to civilian hospitals trained in military record keeping. All of these pamphlets will be sent to each hospital on the continent without cost. This work is an expression of the desire of the medical profession for better care of sick people.

The Accounting Committee desires to correlate all thought and effort relating to hospital improvement problems by all interested groups, and they urge hospitals to adopt that which seems best. We, therefore, earnestly invite and urge cooperation with all groups working on these problems.

We have therefore determined to present just one plan that can readily be utilized by every hospital without any difficulty. It concerns purchases, from their order to their payment.

(1) Purchase orders in triplicate form, on different colored paper, typed or hand-written in one operation.

(A) The original is sent to the party from whom the goods are desired.

(B) The first carbon copy for the housekeeper, receiving clerk, or the one accepting the deliveries.

(C) The second carbon copy retained by the office for reference purposes.

The first carbon copy (B) of this form is retained by the receiving clerk until the goods arrive with invoice. The Purchase Order Form and the invoice are both checked and compared. If correct, they are passed to the clerk, bookkeeper or Superintendent, after being approved by the receiving clerk, for such further entries or attention as is customary or desired, but usually held until the bill is received.

This checked purchase order and checked invoice with the bill is then passed to the committee that audits all such orders for payment. If the House Committee, Finance Committee, Budget Committee or whoever is required to give the matter attention, passes it, and it is O. K'd. by the superintendent, it is then ready for payment. A check is used in simple voucher form with a plain buff colored paper, numbered same as check, and both are typed in one operation with the aid of a carbon. In addition to containing the ordinary matter, it is arranged so that the name and the address of the person for whom the check is intended can be inserted together with the voucher number and other similar desired information. This check requires only the signature of the treasurer, and it is then ready for mailing in one of those so-called window envelopes.

When the check has passed through the bank, it is then filed in numerical order.

The carbon copy of the check, with the bill, invoices, and copy of purchase order are attached together and filed with paid orders of that month, so that the entire transaction from the ordering of the goods, including the invoice and bills and a copy of the payment on each separate purchase, is complete together, and shows the entire transaction from its commencement to its termination.

All other bills of that month are together in this one envelope or file, and each part of the transaction is cross-checked.

In many hospitals these various parts to an order are kept separately so that it is necessary to look in several different places when complete information about any transaction is required.

It therefore seems to your Committee of Accounting that, irrespective of conditions within your own institution or general affairs, this plan can be instantly adopted to your benefit and advantage.

CORNELIUS S. LODER, Chairman.

Report of the Legislative Committee

The present constitution of this association provides that the Legislative Committee shall, so far as possible, inform itself concerning all legislative procedure affecting the association or the interests which it represents and communicate the same to the association by an annual report or by such other means as the trustees may approve. It seems to be the established custom of the Legislative Committee to report to the association at each convention about legislation of particular interest to hospital people. As a rule, such reports have described legislation already on the statute books. While it is conceded to be an advantage to hospital people individually and collectively to have such information, it is the opinion of your Legislative Committee that for constructive purposes such procedure can be likened to the policy of locking the barn door after the horse has been stolen. The making of such reports and the listening to them on the part of the association does not make it possible for the association or its Legislative Committee to exert influence in behalf of wise hospital legislation and against unwise legislation. Along these lines, therefore, the committee has nothing to report.

Two important legislative matters have been assigned to the Legislative Committee during the year, and a third responsibility has been assumed by the committee.

FEDERAL INCORPORATION OF THE AMERICAN HOSPITAL ASSOCIATION

On December 12, 1917, the Legislative Committee was requested to draft a bill for the Federal incorporation of the American Hospital Association and submit the same to the trustees for approval. These instructions were complied with, but for three months the bill was pigeon-holed in Washington. When returned to the committee in the same form but with instructions to redraft it for approval by the trustees, no further action was taken toward its introduction. It was the opinion of the United States senator who had agreed to sponsor the bill, if introduced, that it would be side-tracked because of important pending war legislation. The committee recommends that the association go on record at this convention in favor of incorporation of the association provided that state incorporation be sought if Federal incorporation be found impossible at this time.

THE FEDERAL INHERITANCE TAX

The procedure followed by the Legislative Committee in opposition to this provision of the proposed Federal Tax Law and in support of the Rainey Bill, H. R. 9223, is familiar to the members of this association. Copies of the Rainey Bill and the Bulletin of the Legislative Committee on this subject have been made available to all. In spite of the fact that the hospital point of view as em-

phasized by the Legislative Committee is not likely to be fully accepted by Congress, the committee recommends that the association go on record as opposed to the Federal Inheritance Tax provision of the Tax Bill as related to hospitals, and in support of the Rainey Bill; also, that the Legislative Committee be instructed to send a communication embodying the attitude of the association on this proposed legislation to the proper committees in the United States Senate and in the House of Representatives.

SICKNESS AND HEALTH INSURANCE LEGISLATION

So far as the members of this committee know, no scheme of so-called compulsory sickness or health insurance has been enacted by any state legislature in this country. However, legislation in eight states has been enacted authorizing the appointment of commissions to study the subject and report recommendations. These states are California, Connecticut, Illinois, Massachusetts, New Jersey, Ohio, Pennsylvania, and Wisconsin. The Massachusetts State Commission made a report on social insurance in January, 1918. The other state commissions, most of them only recently appointed or organized, are now at work. One or two are already beginning to analyze their data, tabulate their findings and consider legislative recommendations.

The committee has corresponded with the commissions of seven states. It believes that hospitals are vitally concerned with health insurance proposals. In fact, there can be no comprehensive plan of compulsory sickness or health insurance without hospitals or a hospital system. The social service department of modern hospitals and dispensaries are prime essentials to any program for health insurance, if health insurance contemplates medical and hospital care to the extent of reconstruction and rehabilitation of the individual. Health insurance will revolutionize hospital responsibilities.

With the thought that these commissions might soon recommend legislative proposals, the committee has sought to learn their plans for the use of existing public and private hospitals and their ideas as to the sufficiency of medical and hospital care to be provided for the individual, as well as what they are considering as the proper basis for the determination of rates and charges of such medical and hospital service. The information so obtained is most interesting. It indicates the necessity of prompt and effective action on the part of the American Hospital Association, as well as the various state hospital associations, if they expect to be the factors they should be in legislative proposals having to do with compulsory sickness or health insurance.

Hospital workers and hospital associations seem to have been somewhat indifferent heretofore to the subject of hospital benefits under Federal and state workmen's compensation commissions. If they have not as yet learned the injustice resulting to injured workmen and to hospitals themselves from such indifference, then they never will. Too long have we hospital people sat idly by and let state legislatures and workmen's compensation commissions make plans for the hospital care of injured workmen without careful thought for the sufficiency of the care and with almost no regard for the cost to the hospital of the service rendered. Although there is a tendency to enlarge medical and hospital benefits in new laws and amendments, it is true that most of the compensation states place an absurdly low limit both as to the length of time and as to the amount allowed for medical and hospital care. Some states give no medical benefits while some place the time limit as low as two weeks and

the cash allowance as low as \$25. Do they call this adequate medical and hospital service? And in addition, few states within the knowledge of the members of this committee have given more than a limited recognition in the workmen's compensation legislation or their administration of the same, to the principle of "hospital cost for hospital service rendered" to the injured workman.

Under present compensation laws, generally speaking, the state seeks to provide adequate hospital and medical care for the injured workman as a matter of justice; it must be paid for by the employer as a proper charge against industry; the state as the protector of human life has so decreed. Then the state talks to the hospital providing care in this inconsistent language: "It makes little difference to the state what this service costs the hospital; we will fix the rates and determine the number of days to be paid for; you can do charity work for the state and for the employer." As a typical example, only recently one state commission congratulated itself, and the hospitals of the state as well, that it had increased the weekly rate for such hospital service from \$15 to \$18 a week, although this compensation was considerably less than the average daily per capita cost of the service rendered.

But pass over the question of fair compensation to hospitals. Think what this policy of the state means—this policy of arbitrarily limiting by legislation or otherwise the number of days or weeks of hospital treatment. It affords little opportunity for the complete restoration of the workman seriously injured in industry. In a large measure, it defeats the fundamental purpose of workmen's compensation. Unless we hospital people awaken to the danger and prevent it, not only will hospitals have precisely the same experience under health insurance laws, but, what is of far greater importance to humanity, the sick, who should be entitled to complete rehabilitation as a matter of justice, will become, in part, objects of charity.

Now what is the present attitude of these commissions toward the question of compensation to hospitals? One commission which has recommended a bill has not taken up the question. Three commissions have not considered this phase of the subject, but are considering the general proposition of the necessity of health insurance. One commission has a tentative agreement to the effect that the cost must be based on the actual cost to the hospital, all arrangements to be left to the administering department and not to be written into the law. One commission has formulated no conclusions as to the best method of meeting this problem but wishes that the American Hospital Association would make suggestions as to how medical treatment could best be administered under health insurance. One commission, although it has formulated no definite policy as to health insurance, has gone on record in favor of the most adequate medical and hospital care as a fundamental in any health insurance scheme, and has recognized that hospitals cannot be expected to furnish service for less than cost. To be sure, these commissions have not as yet formulated much of anything in the way of policy or program for legislation. Yet some have official or unofficial opinions regarding the compensation question. The important thing, however, for our purpose is that practically all of them seek information and desire assistance.

Your Legislative Committee believes it is the obvious duty, both of the American Hospital Association, through its Legislative Committee, and of the state hospital associations, to take an active part in advising and assist-

ing these commissions as regards hospital and medical benefits. The letters to your Legislative Committee from these commissions may very well be interpreted as invitations to the American Hospital Association to do so.

Your Legislative Committee, therefore, recommends: (1) That the American Hospital Association go on record in favor of hospital and medical benefits to those insured under Sickness or Health Insurance laws to the extent of restoration in wholesome working and living conditions, so far as it is possible; (2) That the American Hospital Association go on record in favor of the principle of "hospital cost for hospital service rendered" as applied to the proposal for compulsory sickness or health insurance; (3) That the Legislative Committee, subject to the approval of the Board of Trustees when the association is not in session, be and is hereby instructed to render such advice and assistance as it can to the various state health insurance commissions and to urge these commissions to include in their recommendations for legislation the principles emphasized above.

HOWELL WRIGHT, Chairman,
OLIVER H. BARTINE,
GEO. O'HANLON, M. D.

Report of the War Service Committee

At the last meeting of this Association resolutions were adopted in which it was set forth that it was its desire to cooperate to the greatest possible extent with military authorities and with the American Red Cross, and that, in order to be fully prepared for service, a committee be appointed "which shall, as far as possible, inform itself of all military needs in which hospitals may be concerned, be in readiness to consult and advise with military authorities, to take such action as may be important, and, in general, to assist in every way where hospital service may be of value to the country."

Following these resolutions your trustees appointed a committee which has since been known as the War Service Committee of the American Hospital Association, and this committee has, in accordance with your desires as expressed in the resolutions, endeavored to keep informed as to military hospital needs and to cooperate and assist in every way possible.

It was deemed important, in view of rapidly changing conditions, to have a representative regularly in Washington, and headquarters were therefore established at the Washington office of the association. The Statistical Department of the Medical Section of the Council of National Defense was collecting information which coincided in a large degree with that desired by your committee, and at its invitation the freedom of this office was available. The chairman was also made chairman of the Hospital Committee of the Council of National Defense. This association and collaboration have been of great benefit to us, and we hope the benefit has been mutual. Although both organizations were serving in a common cause, nevertheless we are glad to express our appreciation of this friendly cooperation.

It was soon evident that with the hospital as a basis the work of the committee was led into many and varied fields. Questions involving physicians, interns, medical students, medical schools, nurses, nurses' aids and their training, supplies, construction of civil hospitals, additional facilities for the care of congested industrial populations, and questions under the Capital Issues Committee, War Industries Board, Federal Board for Vocational Education, War Risk Insurance Bureau, and Public Health Service, all concerning important issues collateral

to hospital problems, as well as the more definite problems of hospital planning, construction, equipment and administration were met. Every week has brought new problems, and these your committee, after careful consideration, has endeavored to aid in solving.

It was essential to have at hand as complete information as possible, and from time to time questionnaires have been issued and information has been sought from members of the association and from hospitals in general. It was realized that hospitals had been asked for much information by many different organizations, authoritative and otherwise, and were perhaps weary of responding to repeated interrogatories involving many repetitions, but the questions which have been asked have been ones with definite relation to a pertinent problem. It is to be regretted that the responses were not as universal or as carefully made as was hoped, and this failure to respond prevented an accurate and complete diagnosis of conditions, although affording a basis for estimate. Undoubtedly many other questions will be asked before our work is done, by others, if not by your own representatives. May we express the hope that, however tiresome and apparently unimportant they may seem, prompt and careful replies be made.

From the first, certain policies have been advocated by the War Service Committee. Most important are the following:

1. *Existing hospital facilities should be used so far as possible for military purposes*—The Association, by a resolution adopted last year, advocated this policy, and your committee has gained no information during the year which would lead to a change of opinion. Under great misapprehension the authorities have apparently believed that it was the intention to place soldiers in spaces necessary for civilian occupation and intermingling with civilian patients. This was never advocated, but, as a matter of necessary conservation, we have believed, and still believe, that the administrative departments of hospitals, such as operating rooms, laboratories, and x-ray facilities could be used most economically and efficiently, simply by utilizing vacant spaces in hospitals for military wards, or by the construction of additional living spaces in proximity to existing hospitals where this could be done.

We have believed that it was a fundamental necessity to hospitalize returned soldiers as near their homes as possible. This policy is the announced policy of the Surgeon General of the Army. But to accomplish this over one hundred thousand beds must be provided in over forty different locations, and the cost of construction and equipment of complete operating and scientific facilities on such a scale is apparent. It is also to be considered that a very small proportion of returned soldiers will require operative interference, while the comparatively few that do are entitled to the best. A survey of the situation leads to the belief that by proper organization existing facilities are readily sufficient to do all the operative and laboratory work required in the most efficient way. In considering this problem it must be borne in mind that, in addition to the hospitals for returned soldiers, provision must be made for cantonment, camp, embarkation and debarkation hospitals at home, and for a very large number of hospitals abroad, most thoroughly equipped with operating facilities. There must, therefore, be a great demand for hospital and laboratory equipment and supplies which will be difficult to meet, the unnecessary duplication of which will place an undue burden on mechanical resources already strained.

2. *Hospitals for returned soldiers should be located in centers of population*—It follows from the above that

these hospitals should be established in centers of population and where there are the best medical, industrial, and transportation facilities; and your committee has cooperated with the Hospital Committee of the Council of National Defense in advocating the establishment of general hospitals for returned soldiers along three main transcontinental railroad routes and in places which meet the requirements above described. The original basis advocated by the Surgeon General's department was a hospital in each of the draft districts, but it was found that there was no correspondence in the various districts with relation either to area or to population, and it is believed that draft districts afford no basis for the allocation of hospitals.

3. *Physicians at home should be utilized for military service*—We have advocated and still advocate some organization by which the services of physicians who must remain at home can be made available for the care of returned soldiers. A survey indicates that before the war, over five thousand physicians were teaching in Class A medical schools. Some of these have entered into active service, but many must remain; and, in addition to these, are men who must still remain at their posts, either on hospital staffs or for other civilian requirements. We can see no essential difficulty in making use of these men, necessarily including the most skillful in the profession, and, in addition to the skillful medical attendance thus acquired, relieving the shortage of physicians for active service, which will be a very serious problem unless conservation is used.

4. *Volunteer hospital assistants should be used*—We have advocated, and still advocate, the use of volunteer hospital assistants, more generally heretofore referred to as nurses' aids, and in England, as V.A.D.'s.

Surveys made by various parties show clearly that the available supply of trained nurses is not sufficient to meet military and civilian needs, and the Surgeon General's department has recently announced that it desires to make use of this type of service under certain conditions. These conditions, however, are, in the opinion of the committee, not compatible with the requirements. It is believed that there are a large number of women of intelligence and of sufficient means to offer their services as a patriotic duty, who do not wish to enter the nursing profession as a means of livelihood, and have no desire therefore to be fully trained in the profession of nursing. Reports from abroad indicate that, with an intensive training in the service which may be required of them, women of this type have proven most useful and entirely competent to do the work to which they are assigned. Many hospitals have, in anticipation of this need, inaugurated courses of training. It is believed that these courses should be standardized and that the requirements under which hospital assistants may do their work should be duly considered, so that there will be a thorough understanding on the part of all concerned.

The establishment of army training schools for nurses requires serious consideration. The difficulties of giving a thorough nursing education during the stress of war are obvious and, from the point of view of hospitals, methods of supplementing the courses available in the army schools by affiliation with civilian hospitals present problems involving questions of finance, accommodation, and opportunities of instruction, largely increased by the successful efforts of many hospitals to increase their training schools to their highest capacity. Should not these questions be fully considered by your representatives in consultation with the army representatives before negotiations are made with individual hospitals?

The situation with regard to interns is still very unsatisfactory, especially in the small hospitals. Under the new draft law and the educational plan of the army and the Surgeon General's department, it may be possible to contrive a method which will bring some relief. Certainly medical students should have hospital experience under competent supervision to fit them for their army work, as well as for the general practice of their profession, but only such hospitals as recognize their educational duty toward interns and see that it is performed, should expect consideration in this regard. It will be the duty of your War Service Committee during the coming year to keep this important subject in mind and do what they can to bring about the best possible adjustment.

For many years the value of industrial training for cripples has been appreciated by hospitals in industrial centers. Difficulties in providing proper facilities for such training and lack of necessary funds have prevented an adequate development of this important hospital function, although industrial needs are far greater than those anticipated for wounded soldiers. Interest inspired by the war has hastened the development of vocational training by many years. The Federal Board for Vocational Education has broadened the scope of this work, and funds to assist in such training will be available in the various states. The work, as far as industrial cripples are concerned, should, of course, be carried on in connection with hospitals, and, while the immediate consideration is for war work, the future should not be disregarded; and this association should consider means of cooperating with the Federal Vocational Board. One of the reasons for advocating the distribution of military hospitals in industrial centers is in order that the vocational work inaugurated for crippled soldiers—necessarily of a temporary nature and, we all hope, covering not a very extended period—could be put on a permanent basis by using the facilities originally provided for the industrial training of wounded soldiers for the industrially crippled, after the war is ended.

The War Risk Insurance Bureau is another department of the Government which has intimate relations with civil hospitals. It is the policy of the Surgeon General's department not to discharge soldiers until their cure is as complete as the medical man may make it, but experience has shown that after discharge from hospitals, there are recurrences of old troubles, or physical difficulties resulting therefrom, after a considerable period, and these may be anticipated in connection with diseases and injuries resulting from war. Such cases must be taken care of by civil hospitals, largely in cooperation with the War Risk Insurance Bureau, with which many hospitals have already established relations. The scope of these relations should be considered and standardized by this association.

The new draft law creates new difficulties for hospitals, both with relation to their employees and the members of hospital staffs. As to the former, hospitals have been placed by the War Industries Board in Class 1 of essential industries, so that the employees of a hospital may be placed in the deferred list; and hospitals should claim exemption for employees who are essential to the proper conduct of the hospital plant. This, of course, applies to engineers, firemen, laundrymen and others, it being understood that hospitals will not take advantage of this opportunity to hold employees when their places may be filled by women or by men incapable of military service.

With relation to the draft of physicians, it is understood that the importance of retaining physicians on hospital staffs and in other civilian engagements necessary to the public welfare, is fully recognized by the authorities, and

that a plan is being considered whereby hospitals will be properly, but not unduly, protected. In order to prepare for this situation a circular has been sent to hospitals requesting that rotary service on hospital staffs be done away with so far as possible, and, as has before been suggested, it is also hoped that some plan will be adopted whereby the men who remain at home may be used for the care of soldiers returned to this country.

Many of the propositions here touched upon will be brought to your attention more fully during the course of the convention. A great many patriotic people have believed that any policy adopted by the government, or any of its departments, should not be criticised, but this committee has believed that where, after careful consideration, policies either adopted or proposed were harmful or capable of improvement, it was our duty to point out errors and offer criticisms and suggestions, it being understood, of course, that this should not be done concerning matters of fact, except with thorough knowledge of the situation, and that, as to matters of opinion, individual ideas should not be advanced, but that criticisms should be based on the concurrent opinion of several authorities competent to judge. Such fair and constructive criticism is the foundation of democratic success.

It is therefore hoped that, as the various papers are presented introducing these problems more directly, they will be followed by a full and frank discussion so as to bring about a thorough understanding of the situation, and if it should seem expedient, definite action by vote of the members of the association. In this connection, it seems obvious that there is much work which may be done by a powerful organization of hospitals with a thoroughly competent representative always at work in the interests of the members of the association, and that the membership should be largely made up of the hospital organizations themselves rather than that the whole burden should be placed upon the shoulders of their executive officers, as has been done in the past. With this in mind, the War Service Committee joins with your Legislative Committee in recommending your earnest attention to the plan for institutional membership.

S. S. GOLDWATER, Chairman.
A. R. WARNER,
D. D. TEST,
R. P. BORDEN, Secretary.

Some Aspects of the Program of the Medical Department of the Army and Their Effect on Civil Hospitals

By WINFORD H. SMITH, Colonel, M. C., U. S. A.

I am very glad of the opportunity of addressing this association for we realize the spirit of unrest prevalent among the authorities of the civil hospitals, due to a natural anxiety as to what the future holds for those institutions. I shall very briefly outline the program of the Medical Department, touching on some of the problems in which I know you are most interested. It has seemed to me that a brief presentation of the plans, devoting the greater part of the time to discussion and the answering of questions which you may wish to ask, would be most satisfactory and helpful to you.

Brigadier-General Richard, the Acting Surgeon General, desires to extend to you his best wishes for a successful and profitable meeting. He is deeply conscious of the many problems which you have had to meet as a result of the war and appreciative of your splendid cooperation and help whenever you have been called upon. It is inevitable that the civil hospitals should be vitally affected by the war program, and there is every disposition to

be as considerate of their interests as the exigencies of war permit.

First, I wish to repeat in substance what I said to you a year ago as the representative of the Surgeon General's Office. The program of the Medical Department calls for the establishment of its own hospitals under military control in various parts of the country and in sufficient number to handle all of the major needs. It has not seemed practicable to depend upon the civilian hospitals to assist in handling the care of the large numbers of sick and wounded from the large camps and from over-seas, for the reason that the beds of civilian hospitals are likely to be needed for the civil communities, and because it is considered impracticable and undesirable from a military point of view to scatter soldiers in such small numbers as would be necessary under such an arrangement. Your War Service Committee has not agreed with our program in this respect, but the matter has been given the most careful consideration, and we are unable to see it from any other point of view.

Military hospitals will, so far as practicable, be established in the draft districts, in order that the majority of the sick and wounded requiring general hospital treatment may be cared for in hospitals located within their home zone and within reasonable distance of their friends and relatives. This plan is being, and will continue to be, modified as conditions may require. In establishing these hospitals, existing military posts are being utilized to avoid new construction as much as possible. In addition to these posts, existing buildings such as hotels, colleges, and, in several instances, entire hospital plants, are being used. Hospital plants will be so utilized whenever feasible. It is estimated that, over and above some sixty thousand beds provided in the base hospitals of the large camps, we shall require, not immediately but within another year, approximately one hundred and thirty-five thousand beds in this country. This figure is inclusive of the general hospital beds already established. This program is being steadily developed with the approval of other War Department authorities.

I know you will appreciate at once the magnitude of the task, and I am sure you will agree with me that what has already been accomplished in approximately one year augurs well for the future. In that time about sixty hospitals, averaging over one thousand patients' beds in each, have been put into operation, over half of which had to be constructed from the ground up. This, with the development of the necessary organization, staff and equipment, represents a considerable accomplishment for so brief a period.

It has been my privilege to inspect many of these hospitals, and, speaking as a civilian hospital administrator, I have no hesitancy in saying that in the main these hospitals are doing as good work as—and often better work than—is done in the best civilian hospitals. This has been made possible by the experienced organizers of the regular Medical Corps and the splendid response and cooperation of the medical and nursing professions. I am firmly of the opinion that you and the fathers and mothers of our soldiers may rest assured that every effort is being and will be made to afford the wounded soldier adequate care and attention at all times.

Hand in hand with the development of the hospital program goes that of physical reconstruction. For the past few years the subject of rehabilitation and reeducation of the physically handicapped has received considerable attention before this association, evidencing an increasing appreciation that our hospital system is lacking either in a fundamental or a cooperative factor which

would make possible a finished job in dealing with the handicapped. The problem is not new, but more acute because of the war. Profiting by the experience of our allies, extensive plans are being made to meet the problem of reconstruction and reeducation of the soldier in the best possible way. It will at once be evident to all that to solve the problem successfully for the soldier will undoubtedly point the way toward, if not establish, a permanent basis for handling the industrial cripple and the physically handicapped generally.

The Medical Department of the Army is providing in all of its reconstruction hospitals a system of occupational therapy sufficiently elaborate to insure proper treatment to the end that the soldier may obtain complete restoration of function, or as complete as may be possible under the circumstances. In accomplishing this, the aim is to conduct the treatment in such a way that, by the time the soldier is ready for discharge from the army, he may be turned over to the Board of Vocational Training for final training, having gained as much as possible in that direction by careful selection and supervision of the occupational therapy in the hospital. This is being provided for by the establishment of the shops in connection with these hospitals and by the employment of competent occupational teachers. An agent of the Federal Board will also be stationed in each hospital in order that the progress of the patient may be constantly supervised through his period of treatment to his final vocational training after leaving the hospital, with as little interruption as possible. This is one of the big problems to be met, and fairly complete plans are in hand.

In order to accomplish the task before the Medical Department, it is estimated that approximately forty-six thousand physicians will be needed and at least fifty thousand nurses, all in military service. About thirty thousand physicians are now available or on duty, and over seventeen thousand nurses are actually in service. You may wonder why so many more physicians than nurses in proportion are required. The answer is that thousands of physicians are required in field service and in the advanced areas where nurses may not go.

You will ask what effect all this is to have on the civil hospitals. The Surgeon General's Office has in every way tried to safeguard the supply of physicians for civil hospitals by the establishment of an inactive list and by its readiness to cooperate whenever possible. It was impossible for the Surgeon General to prevent a physician from leaving his civilian post if he insisted upon entering the service, and this has been largely responsible for the embarrassments which you have suffered. It is still optional with physicians outside the draft age whether they enter the military service or not, and it is therefore incumbent upon local authorities to persuade those who are essential to remain at home. The same applies to graduate nurses. The public and the civil hospitals must, however, recognize the needs of the army and must be content to run with a staff reduced to the minimum, and I think that in the main this is fully appreciated.

There has apparently been some confusion and misunderstanding concerning the physicians' Volunteer Service Corps and its relation to the Medical Corps and the Medical Reserve Corps. This organization has been developed under the auspices of the Medical Section of the Council of National Defense, and should in no wise be confused with the Medical Corps or the Reserve Corps. Strictly speaking, it is not a Government organization. In some localities physicians have obtained the impression that they must either join the Volunteer Service Corps or the Medical Reserve Corps. This has resulted in the

filing of many applications for commission by those who are not in a position to accept service. The Surgeon General does not wish anyone to apply until he is ready to accept active service. As a matter of fact, any physician now granted a commission will be obliged to accept active service almost immediately.

It is appreciated that, by changing the draft age to 18 to 45, many new problems have arisen or old problems have become more acute, such as the continued supply of interns and staff physicians and, what is quite as important, the supply of employees. Having this in mind, General Richard, Acting Surgeon-General, recently addressed a communication to the Provost Marshal General requesting that hospitals be placed in the class of essential industries and that members of the professional and administrative staffs be considered eligible for exemption, and that the draft boards be so notified. The Provost Marshal General has replied to this request with approval and with the statement that a bulletin has already been issued to the draft boards which so classifies hospitals and places it within the jurisdiction of the district boards to recognize for exemption those who are considered essential in hospital work. This bulletin reads as follows:

"The necessity of not seriously interfering with certain occupations and employments, such as financial, commercial, educational, hospital work, care of the public health, or with the conduct of certain other activities necessary to the public welfare and the prosecution of the war, requires that the District Boards have the cooperation of such advisers, so that persons necessary in such activities be not removed therefrom."

This apparently applies to both professional and employee classes and should do much to clarify and ease the situation for civil hospitals. The needs of the army must, however, be constantly borne in mind, particularly with relation to physicians and nurses.

I have already said that the army will require at least fifty thousand nurses by this time next year. It is of course impossible to obtain this number of graduates; therefore, measures have been taken to supplement the supply of graduates by pupils of the Army School of Nursing and by hospital assistants. It is believed that the plans being developed will prove adequate; if not, they will be modified whenever it becomes necessary. I will not dwell longer on this subject at this time, for this will be dealt with in detail at the special session this evening for the discussion of nursing problems. This point, however, should be emphasized—that the Surgeon General has been mindful of the need of interfering as little as possible with the existing schools of nursing in civil hospitals and has adopted the present plans as guaranteeing the least interference with those schools.

One other problem now presents itself as the result of militarizing universities and colleges including medical schools. This is in no way a discussion of the wisdom of such a step, but is merely intended to answer some of the questions which are being asked and which you are sure to raise.

If the medical schools are militarized and all students drafted into the service, where are the civil hospitals to obtain interns a year hence, and how can men be retained for the resident or upper staffs? These questions are now under consideration, and it is to be expected that satisfactory answers will be found. At present it appears that only those who are physically disqualified and women physicians will be eligible for staff appointments for a period longer than one year. As for the supply of interns, while no definite decision has yet been reached, it is expected that medical graduates will be allowed one

year's internship before taking commissions. The question will naturally be asked, "Is the internship or the commission to be left to the choice of the individual?" This question will be prompted by the feeling that if it is optional very few men having had a year of service in military life will choose internships in civil hospitals. This is undoubtedly a vital question to the hospitals. At present the disposition of the Surgeon General is toward making the intern year a requisite for commission. If this is established, the supply of interns will be assured. No decision has yet been made, however.

While students, the men will be furnished free tuition, maintenance, uniforms and the pay of a private, according to the present plans of the War Department. What will be their status as interns? It is impossible to answer that question definitely at this time. It is probable, however, that they will either continue as enlisted men in service under training, and continue to draw the private's pay, or that the hospitals will be expected to pay the intern instead of the Government, the period of internship being considered as an indefinite furlough. Both of these methods are under consideration. In any event it appears that measures will be taken to safeguard the supply of interns, which, from your point of view, is the vital question. As an indication of the attitude of the Surgeon General's Office in safeguarding the civil hospitals, may I point out, of the 2,300 graduates of the class of 1918, 1,200 have been definitely authorized by the Surgeon General's Office to remain on inactive duty for one year intern appointments? Only sixty-five of the 2,300 graduates are on duty in the army and 193 in the navy, according to the figures furnished me. There are 285 enlisted privates of the Medical Enlisted Reserve Corps who have not yet applied for inactive duty for intern appointments, which is partly the fault of the interns and partly the fault of the hospital in not using every effort to see that their interns are authorized to continue on inactive duty. Every intern and every 1918 graduate has been advised that the regulations practically require him to have a one year hospital service before he can expect a commission. At the least, nineteen hundred of this year's graduates are interns in hospitals, which is probably as large a proportion as in any previous year. These are the figures furnished me by the division of the Surgeon General's Office, charged with the responsibility of handling the intern and medical student problems.

The Nursing Program of the American Red Cross

By JANE A. DELANO, director Department of Nursing, American Red Cross

The Red Cross organizations of the world developed primarily out of the need of nursing care for the sick and wounded of armies. Two important factors leading to the development of the Red Cross organizations were the work of Florence Nightingale in the Crimea and the neglect of the sick and wounded after the battle of Solferino. That nursing the sick and wounded of armies was recognized primarily as one of the chief functions of the Red Cross, is shown by the fact that providing such nurses was mentioned in three of the six articles of the Red Cross Geneva treaty, dealing with the subject of nursing personnel.

The responsibility for the development of a nursing service was accepted in the reorganization of our own Red Cross in 1905 as one of its functions. It was further believed that such service should be definitely related to the needs of the army and navy. At the request of the Surgeon General of the Army, in 1909, the Red Cross un-

undertook plans for the expansion of the service and its adaptation to the needs of the army. So important was this relation believed to be, that regulations were issued by the Secretary of War making the Red Cross Nursing Service the reserve of the Army Nurse Corps, provided by law, and a proclamation issued by the President of the United States at about the same time placed upon the American Red Cross the responsibility of acting as a relief agency to the army and navy in time of war.

As the charter of the American Red Cross authorized the administration of relief in time of peace, enrolled nurses of the Red Cross were at once utilized for this work, and have been freely called into service during the past nine years. Not only was this helpful to the civilian population, but gave an opportunity for practical experience in meeting unusual conditions, and greatly strengthened the allegiance of the nurses of the country to the American Red Cross.

When war clouds threatened between this country and Mexico in 1914, the Red Cross was called upon during the occupation of Vera Cruz by our troops, and remained there until they were withdrawn. This was their first service under war conditions. With the mobilization of the troops on the Mexican border, an increased number of Red Cross nurses was called upon for service as a reserve to the Army Nurse Corps. The number of Red Cross nurses assigned to duty steadily increased with the increase in the number of troops on border duty.

From the first assignment of nurses to duty in Vera Cruz, April 21, 1914, to our own entrance into the war in April, 1917, our Red Cross nurses were continuously on duty with the military forces. With the declaration of the European war in August, 1914, the American Red Cross promptly offered the services of physicians and nurses to each of the European countries involved, and by September 1, 126 nurses were mobilized in New York and ready to sail. Other units quickly followed, and during the first year of the war we had nurses continually on duty in England, France, Germany, Austria, Russia, Servia, and Bulgaria. These units were later withdrawn (October 1, 1915), but many of the nurses volunteered to remain, and we had many Red Cross nurses as volunteers in all of the allied countries until our own entrance into the war.

The experience of the Red Cross in Europe during the first year of the war convinced us that units would be more efficient if made up of physicians and nurses from the same school or hospital, and in the early spring of 1915 the Red Cross, with the approval of the Surgeons General of the Army and Navy, undertook the development of hospital units along these lines. Twenty-five of the leading hospitals of the country were asked to cooperate in the developing of these units and the securing of the necessary equipment for them. Definite instructions concerning the nursing personnel of these units were sent to each of the chief nurses in order that a well-balanced group might be selected, sufficient to meet the needs of a general hospital. The following list was taken as a guide in making selections for service: Each hospital unit was to have one chief nurse, one assistant chief nurse, one night chief nurse, one charge nurse (operating room), five assistant nurses (operating room), one charge nurse for dietitian, one charge nurse (linen room), thirty-eight medical and surgical ward nurses (twenty-eight day and ten night), fifteen reserve nurses (not on roll), four diet kitchen nurses' aids, four linen room nurses' aids, two nurses' aids for nurses' quarters, fifteen nurses' aids for wards, and twenty-five reserve nurses' aids. All nurses' aids must be members of the Red Cross.

Three of the nurses were supposed to have had some practical experience in the care of contagious diseases.

This plan was adopted, not only to provide a well-balanced group of nurses for possible military service, but to prevent the withdrawal of too many executives and specialists from the civilian hospitals.

Because of our organization for two years previous to the war, during the entire year of 1916 we had a long waiting list of nurses willing to accept service here or abroad.

When war was declared in April, 1917, the Red Cross had forty-six base hospital units authorized, and twenty-five were well under way. Seventeen units were assigned to foreign service with a nursing personnel of 1,390, and four additional units were ready, waiting orders to sail, with a nursing personnel of 260, between June, 1917, and January, 1918. In addition to the personnel which had been secured, approximately between \$25,000 and \$35,000 had been collected for the equipment of each unit. Later, it was found that the equipment of base hospital units would cost between \$40,000 and \$50,000, all of which was raised by volunteer subscription.

In the development of these units, it was thought probable that they would be used with the army on the Mexican border. With the movement of our troops to France, however, the plan to utilize these units was abandoned, and several of the base hospital units were sent immediately abroad. As we had relied upon these units for service in this country, this change of plan led to the organization of emergency detachments to be used in our own cantonnements.

With the sudden outbreak of contagious diseases in the cantonment hospitals during the winter of 1917-18, a greatly increased number of nurses was needed at home, and, as several thousand were holding themselves available for service in connection with the base hospital units, it was difficult to convince the nurses of the country that any great need existed, as those already prepared were not being called upon for service. While we believed that unit organization would give the most efficient service, we changed to the selection of individual nurses for assignment as the best way of meeting the emergency demands from the Surgeon General's office, and this plan of selection was put into immediate operation.

A tremendous burden has been placed upon the Nursing Service of the Red Cross and the nursing profession of America during the past four years, and I believe it is not too much to say that the continuous needs of the army have been met at the sacrifice of personal interest and personal desires, and that the nurses of America have responded nobly. Never before in the history of nursing has it been attempted to man large hospitals varying in size from several hundred to several thousand beds with a graduate service of nurses. Nor is it believed that even in time of war this is the best form of hospital administration. It is hoped that the Army School of Nursing will supply the greatly needed supplementary service.

The Red Cross realizes, however, that, as a reserve to the army and navy, it is their responsibility to secure promptly and in sufficient numbers the nursing personnel requested by the Surgeon General.

The Red Cross Nursing Service does not exist solely as a reserve for the Army and Navy Nurse Corps, but maintains a permanent nursing service available in peace as well as in war. When assigned to duty as a reserve to the Army and Navy Nurse Corps they become temporarily a part of it; but when released they are again available for assignment. It is this permanent relation to the

Red Cross which has kept it apart from the more temporary war services, and as such, is has made a very direct and compelling appeal to the nursing profession of the country. With the increasing number of nurses in active service it became evident that the nursing resources of the country must in every way be conserved. In order that assignments might be made to the best possible advantage, arrangements were made with the Surgeon General of the Federal Public Health Service, in the spring of this year, to take over the selection of nurses under that service, in order that there might be no unnecessary overlapping and that the various services and the applications of all nurses should receive equal consideration. This Federal Public Health Service includes all marine hospitals, the base hospitals established for the munition workers at Nitro, West Virginia, Public Health Service in the sanitary zones surrounding the cantonments, and nurses assigned to contagious work at the request of the Federal Public Health Service.

The Red Cross also maintains under its own auspices in Europe groups of nurses in Italy, Russia, Servia, Roumania, England, and Greece, and is supplementing the services of these nurses with specially prepared nurses' aids, who act as interpreters and assist in the hospitals organized under the American Red Cross and the French government. They are also assisting in the infant welfare work and in the care of refugees abroad.

In addition to the definite war service, the Red Cross maintains a permanent Public Health Nursing program and has nearly one hundred Red Cross nurses serving in town and rural communities as members of its Town and Country Nursing Service. It is hoped to expand the work greatly to help meet the conditions incident to war.

We are conducting through our Red Cross chapters various courses of instruction for women, intended primarily to give the simple principles of personal and household hygiene, to prevent contagion and lessen disease. A large number of women, in fact over sixty thousand, have already received instruction in elementary hygiene and home care of the sick under the auspices of the Red Cross, and we expect to extend the scope of this work during the coming year. It is believed, by such authorities as Miss Julia Lathrop, of the Children's Bureau, that, if we are to meet war conditions in the best possible way, women must be prepared to occupy the same relations to their families as they held during the period previous to the use of hospitals and graduate nurses—in other words, that women must be taught to maintain, as far as possible, the health of their households, and to care for minor illnesses in their own homes, in order that communities may be safeguarded and a reasonable number of nurses released for military service.

Under the Department of Nursing, a Bureau of Dietitian Service is also conducted, which has enrolled during the past two years over 1,620 dietitians, and has assigned about three hundred to active service, either in military hospitals, at home or abroad, or directly under the auspices of the Red Cross. Most of the remaining enrollment are listed in division offices as instructors. Courses of instruction are also directed under this bureau in home dietetics, emergency cooking and war diet in the home, once more aiming to fit the women to care for their families and to cooperate in the relief work brought about by the needs of the war.

In order that all of the nursing resources of the country might be available for the service for which they were needed and best qualified, the Red Cross has authorized three classes of enrollment—enrollment for active service, consisting of those nurses sup-

posed to be available for military duty; home defense nurses, who are unable to respond to call for active service but might be able to give all, or part, of their time to their own communities, such as married nurses, or those who are physically disqualified; special service enrollment, consisting of nurses holding important positions who should not at this time be withdrawn for military service. It is believed that practically every graduate nurse in the United States can be listed in one of these three services and made available for service under the direction of the Red Cross or the Army and Navy Nurse Corps.

Our total enrollment at the beginning of the war, April 7, 1917, was 8,015. This represented the total enrollment of nurses from the beginning of the reorganization of the Red Cross in 1905 to that date, and included nurses enrolled for special service, such as committee work and instructors in home care of the sick, and others who were not available for active service, either on account of age or other conditions. An effort was promptly made to stimulate enrollment, and increase the number of available nurses. This was done largely through the development of units, upon which we relied for service. Our total enrollment to date is something over twenty-eight thousand, but, as our enrollments are numbered consecutively, this also represents a proportion of nurses who are not available for active duty. The number varies, but a complete record is kept at Red Cross Headquarters of the exact status of the entire enrollment. To Sept. 1, 1918, there has been assigned to duty to the army 15,174; to the navy, 997; and to the Federal Public Health Service and directly under the auspices of the American Red Cross, 624. Approximately one-half of these nurses are serving in Europe, and one-half in the United States.

A definite campaign to secure twenty-five thousand nurses for service by January 1st was undertaken by the Red Cross in June of this year. An allotment was made to each state on the basis of the number of nurses in each state and the number already withdrawn for service. As a result of this special effort to secure nurses, 1,571 were enrolled in June, 2,668 in July and 2,680 in August. If we are to meet the needs of the Surgeon General's office between now and January 1, it will be necessary for the Red Cross to enroll approximately ten thousand additional nurses.

In addition to the units organized for general hospital service, we have selected for service with the Army Nurse Corps, a group of sixty-five psychiatric nurses for a special hospital in France. Every member of this unit had had unusual experience in the care of the insane and the various phases of the work. We have selected special groups of nurses for infant welfare work. We have aided in securing the personnel for a large fracture hospital, also for orthopedic service, for head and neck surgery, and have now in Europe serving under the Red Cross nurses especially qualified in public health work, infant welfare work, and in educational work to act as instructors to native women to prepare them as assistants in war service. We have a large number of French and Italian women receiving such instruction from nurses especially qualified for this service.

In reviewing the work of the nurses of America, we have faith to believe that they will continue to respond to the needs of their country, and to cooperate with the Red Cross in supplying the nurses required to care for our sick and wounded in France, and in the cantonment hospitals in this country. They will not, I feel sure, want to be "among those missing," when the roll of honor is called after war is over.

The Relation of the War Program to Nursing in Civil Hospitals

By ADELAIDE NUTTING, chairman Committee on Nursing, General Medical Board, Council of National Defense.

As soon as we had entered the war, it seemed clear in the very nature of things that there would be problems to meet which would not fall within the province of any existing body to handle. The Army and Navy Nurse Corps had well defined tasks and would, of necessity, move in their own prescribed orbits. The Nursing Department of the Red Cross had many activities, but, as the great recruiting agency, it would be largely occupied with the colossal problem of keeping up the nursing reserves. These could proclaim their needs and they were paramount, but there should be, it seemed, some other body constantly at work to help in finding ways of meeting them, to forward and supplement their efforts and also to look to the nursing needs of the civil population. Such a body would be concerned with the care of the sick in civil hospitals and homes, with the problems of training schools for nurses, and with such emergencies in nursing as might from time to time arise during the progress of the war. It was further realized that new problems in nursing must inevitably follow the war and that careful and serious study in preparation for them should begin at once. Hence, there was formed an Emergency Committee of Nurses (and others), which later became the Committee on Nursing of the General Medical Board, Council of National Defense.

I assume that I am asked to speak here tonight of the relation of the war program to nursing in civil hospitals, because it is to that particular problem that the Committee on Nursing has since June, 1917, devoted the larger part of its time, thought, and resources. As chairman of that committee, whatever I have to say must necessarily be drawn from its activities and experiences.

What the war really was going to mean to our hospital training schools did not, I am confident, come home with any great force to most of us until we saw the first base hospital units sail for France and realized how, in a moment, there had been swept out of our educational structure, never strong enough for its work, superintendents, assistants, supervisors, instructors and head nurses, and, in some instances, several of those officers from one hospital school. Public Health nurses, too, so few in number, were drawn into the tide that flowed to the military hospitals in France. Well prepared as we believed ourselves to be to meet the first call of the war, and eager as we were to meet it, this depletion of the ranks of our executive and teaching body was a revelation. It brought home to us the necessity of taking immediate measures to find and train more women to fill these difficult and responsible fields, and our appeal to the colleges was the outcome. It seemed reasonable to expect that our colleges should supply at least a portion of such candidates and that the college women bringing a sound groundwork in education could more readily grasp the underlying principles of the work and could proceed more rapidly with their training than less prepared students. Moreover, they would bring a larger degree of maturity.

Having secured assurances from several leading training schools that an appreciable reduction in the course of instruction could be made to college women of suitable qualifications, we wrote, explaining the nursing situation and appealing for cooperation to the authorities of every woman's college and all the standard coeducational colleges in the country, and also to many thousands of their graduates. The result has been that for over a year, col-

lege women in constantly increasing numbers have been entering our schools of nursing, and this last summer witnessed a striking phase of the effect of our efforts in the Vassar Training Camp for Nurses. For, without all of the previous work there could have been no Vassar Camp, and the more than four hundred splendidly prepared and enthusiastic young college graduates who are at this time entering many of our representative schools of nursing would have been entering some other field of service.

Vassar is not the only college which has helped to meet the nursing problem. This summer the Western Reserve University at Cleveland, and the Universities of California and Iowa offered the preliminary scientific courses required in the training of nurses to several hundred students all told, I understand; and the hospital training schools to which these students are now going have thus been relieved of the expense and trouble of teaching and maintaining them for this preliminary period.

The next step recently taken forges another link in the chain of cooperation by which we have been trying to unite the higher educational institutions and our hospital training schools. The influence of the Vassar experiment has enabled us to work toward plans through which a large number of selected colleges and universities are now being asked by the American Council of Education to establish pre-nursing courses as a war measure. The circular recently issued from which I quote says these will be for the "purpose of assisting civilian and army hospital training schools to meet the overwhelming demand for adequately trained nurses." These pre-nursing courses should serve to prepare successive groups of young women in various communities all over the country for entrance to hospital training schools and for immediate usefulness after they do enter and it is expected that several thousand students will seek this preparation. Thus the pressure on hospital training schools which has been increasingly heavy because of the need of training large classes with smaller teaching staff, may be in a considerable measure lifted.

I have dwelt at some length on our work in connection with colleges, but not because of its dimensions. The numbers of nurses with which it is concerned will be comparatively small, (though superlatively important), but because it shows a steady persistent effort extending over sixteen months to align the colleges beside us in working toward the solution of some of our most urgent problems. We have at least made certain that, for the higher and more exacting forms of nursing, for the direction and development of our training schools for the instruction and training of future nurses, for the guidance of the workers in the many fields of public health nursing, there will ultimately be available many hundreds of well-trained nurses who have also had the advantages of full college preparation.

Having provided as well as we could for the *line and staff*, our next step was to build up the *working force*.

The needs of the army for nurses were for the time being met, and the immediate future was provided for; but behind that there stretched away a period, and it might be a long one—no one could tell—for which no adequate provision existed. Predictions of the possible demand for nurses dealt in large terms and increased from month to month. The steady expansion of our army made necessary the great development of military hospitals at home as well as abroad, and the call was not only for proper nursing service during the war, but it pointed clearly to enormous demands for nurses in the greater work of reconstruction which would inevitably follow such

expansion. These demands, it seemed, would extend into civil hospitals and would penetrate every form of public health work. For we knew that in the forefront of the great questions which the war at its close will press upon us, which it is even now pressing upon us, stands the question of health, and the part which trained nurses must fill in this field is too important and fundamental to permit us to forget it, or to neglect to prepare them for it in large numbers. We realized, further, that those nurses who had gone into army service might not return for a long time, and a good many would not return at all. Their places would have to be filled.

But there was another question before us. When the needs of the army could no longer be met by graduate nurses, where should we turn? And a few of us at least believed that the very best body in which to reinforce the graduate nurses would be found in the senior classes in our schools of nursing. As approximately fourteen thousand nurses are now graduated every year, that number of senior nurses, young women with at least two full years of training behind them, would be there to draw from; and that these young women were capable of giving excellent nursing service would not admit of question. In estimating the potential nursing resources of the country, therefore, we have never overlooked this possible supply, and that it should be turned to when necessary was our recommendation to the special committee convened in June, 1917, by the Red Cross. We felt that a certain quota could be asked for, and would readily be released by the hospitals if they were in any position to do so. And then we proceeded to try to put them in a position to do it.

We started well over a year ago a comprehensive and widespread campaign of educational publicity. In it we tried to tell people something about nursing and hospitals and public health, to show young women and their parents just how indispensable a field of human effort nursing must always be, and how in great crises like the present it becomes an essential part of national service. We tried to show that the life of the nurse is not only one of surpassing usefulness, but of much personal happiness and satisfaction, and that great fields of public importance were now opening up to her in many directions. We urged every hesitating young woman who, seeking a field of useful activity, faltered at the door of the hospital training school, fearing she knew not what difficulties and severities, to put aside her doubts, to enter and to try to prepare for the service the country most needed, and at the same time to give the hospitals the service they constantly require and for which they must at present depend in large measure upon student nurses. Such appeals were sent forth in many thousands in every state in the country, supplemented by requests to high and private schools to bring the matter before the older students and alumnae. Articles on nursing were published in the daily press and in popular periodicals, addresses were made in schools, churches, and at special meetings. From our office in Washington, a constant stream of advice and information on this subject has poured forth to thousands of inquirers.

As a result, we could point in April to reports coming from between seven hundred and eight hundred training schools (about half of the number of hospital training schools on our lists), which showed that over seven thousand students over and above the usual number had been admitted during the year. As the recruiting has been going on steadily, it seems likely that this number has been somewhat increased in the intervening months. A study of the reports, however, showed us that, while the larger and better equipped hospital training schools

had in most instances a considerable increase in the number of students, there were still a good many hospitals, particularly the smaller ones, which were without applicants and greatly in need of students to carry on their work, for which little other assistance could be provided. It seemed necessary to devise some way of taking care of them. It was apparent also from the increasing demands for nurses for the army that efforts to keep our training schools full in order to replace the nurses called away must not slacken. And at this time the establishment of the Army School of Nursing with its great scheme of student service called for large and immediate recruiting efforts. A new and interesting plan for recruiting was worked out by the Women's Committee of the Council of National Defense, from whom we had previously had much helpful cooperation, in conjunction with the Red Cross and the State Councils' Section, and under the direction of the former a campaign was inaugurated to build up what was termed The United States Student Nurse Reserve and to enroll in it, as applicants to meet the needs of both civil and army schools of nursing, many thousands of well qualified young women. This campaign has been vigorously carried on by the Women's Committee, through its twelve thousand committees throughout the states and with valuable help from the Red Cross, and the reports yesterday showed that 10,458 applicants had already been enrolled, of whom 3,358 were eligible for the Army School of Nursing and 5,982 for civil training schools. Of these, 2,134 have to date been assigned to hospital training schools which have vacancies and need students, and the assignment is going on rapidly. This does not tell the whole story, for there are other recruiting efforts which have been carried on somewhat independently; in the City of New York, for instance, about one thousand seven hundred additional applicants have been referred during the last few months, through the Bureau of Information of the Red Cross, either to the army or to civil schools of nursing.

How the plan is working out can, perhaps, be shown by the following typical letter which comes from the superintendent of a hospital in sore straits for student nurses:

"On behalf of the Board of Managers of — I wish to thank you sincerely for your attention to the matter of assignment of nurses to this institution.

"The names, addresses and credentials of twenty-four members of the United States Student Nurse Reserve have been received, and I am hastening to communicate with them in order that they may report for duty without delay.

"The hospital will endeavor to do its part by giving a thorough and effective training to the young women whose nursing education has been entrusted to its care in this great crisis.

"The question of affiliating with the Army School of Nursing is now under advisement and will receive the early and careful consideration of our Board.

"Thanking you again for your help at this time when the help was most needed, I am,

Sincerely yours, _____"

In several instances nurse applicants who had been referred to training schools which were needing students a few weeks ago found the vacancies already filled through the local interest aroused.

From the outlook as it now stands, I think we can count upon such a substantial increment to the body of student nurses in our hundreds of hospital training schools as will enable them to take care of the sick in their respective communities and later will enable them to release some of their older students for army service if the country needs them. There will undoubtedly, however, be some institutions which we can find no way of helping. Possibly the help they need must come first from within.

Our latest effort to help the training schools of our civil hospitals has led us to appeal to the Federal Board of Vocational Education to extend to schools of nursing some of the benefits it so freely accords other branches of vocational work. This will mean that in a good many schools teachers may be supplied free of expense for certain subjects such as elementary science, dietetics, nutrition, hygiene, etc. This should prove particularly helpful to hospitals in small towns, where it is often difficult to find a good teaching staff. It may be that this will ultimately prove to be the most permanently useful and far reaching thing we have done. It is a great satisfaction and relief to know that many training schools which in the early days of war had few applicants (some of whom were even then dropping from the accepted lists to take the short and easy path provided for "aids") are now facing the winter's work with schools filled to overflowing with the best qualified students they have ever had. Instead of being broken down by the competition of short courses, of the many new occupations for women which have arisen during the war, and of the great increase in demands for women in their old familiar occupations, our schools of nursing have been held up, fortified and strengthened. The majority of them are now working at a high level of productive activity and are, or soon will be, in a position to offer some quota of their senior nurses if the country needs them.

I cannot help feeling that one of the best results of our year's work to interest young women in nursing has been a better understanding by the public, not only of the importance of nursing and the extraordinary opportunity for usefulness which it offers, but of the problems which training schools have to meet, and of the difficulties which hospitals often labor under in trying to maintain good training schools. I am sure this educational campaign of ours will bear fruit for years to come. There will not be so much difficulty getting good applicants. There will be made available in the future for our hospitals and training schools much valuable help and cooperation on the part of the community.

It has been very interesting indeed to see the change in attitude which has come about during the past year. At first almost everybody wanted to take a few weeks' course and go to France at once. Now many young women are realizing that they can do nothing that is worth while without some real serious training and hard work, and they are willing to take almost any training that is prescribed by those in authority. There is a decided reaction going on against short superficial courses of training. What the majority of young women seem to want to do now is to "make good" and to do what their country most needs of them. This seems evident from the hundreds (I might say thousands) of interviews which workers all over the country have had with the girls and women who are volunteering for the nursing service. We have only ourselves to blame if we fail to make the best use of all the excellent material which is coming to us—literally placing itself in our hands. The amazing record of enrollments already in the Army School of Nursing shows how true is the present response to this kind of an appeal. This school is the embodiment of a great idea, and its plans are being worked out in a statesmanlike way. In its own sphere it falls in line with the feats in shipbuilding and with the scheme which finds a way of hurrying a million troops across the Atlantic in a few months. To organize thirty or forty or more training schools in swift succession and to bring in a few months thousands of highly qualified young women into serious training for the service of the country is an achieve-

ment. The Army School *can* provide our main future supply of nurses for the army, and it should have our fullest cooperation and support.

So far I have tried to show how war has affected nursing in our civil hospitals. Its future effect we cannot altogether foresee, but changes are foreshadowed, and some of them are already taking place. It is evident that the three years of training, if it is to remain, must serve to prepare nurses for a wider service than it has hitherto included. Whatever may have been the demands of the past in nursing to which the training schools have tried to respond, the needs of the future will make new considerations inevitable. In the slow and painful readjustment which is before us when we cease the industries of war and resume the activities of peace, we must give new kinds of care and protection to the health of our people. The program laid down by the British Labor Party will probably be in a measure our own program, and it includes a Ministry of Health, the safeguarding of motherhood and infancy from privation, and adequate public provision for the reduction of sickness and injury to a minimum by prevention and proper treatment. Definite instruction for nurses in the subjects most vital to public health and careful training in the problems with which the public health nurse must inevitably deal, are therefore now clearly called for. Whether she works in the homes among young mothers and infants, in the schools among school children, in the factories among young girls or any employees who need advice, guidance or actual service, the nurse has become for the future the prototype of the one to whom we must increasingly turn to help maintain our home and health defenses. If we must turn to her, we must train her; and, whatever comes later after her hospital training, the groundwork must be laid in the training school, and the process must be as sympathetically and intelligently conducted as we know how to make it. And because the need is with us, striding beside the need of the army and keeping pace with it, we must be at work upon that problem *now*. We must eliminate the great waste of women's effort that goes on in many of our hospitals, reduce the amount of unskilled and unnecessary labor so frequently a routine part of the training of our student nurses, enlarge the amount of sound and substantial knowledge now required and provide nurses with a wider outlook upon life's real problems. It is probable that an earlier and larger place in the scheme of training must be given to the care of infants and young children and obstetrics. It seems certain that more thorough and comprehensive teaching in the subject of communicable diseases is called for and that some acquaintance with mental diseases is certainly most important. A training which covers three calendar years should include these matters if it is to render its full measure of usefulness to society.

The war program in relation to nursing in civil hospitals must go, therefore, far beyond efforts to maintain in them an ample and efficient service during the vicissitudes of the war. It must go beyond enlargements of the schools by continuous influx of students to form the nursing reserves of the army later. It must take into consideration the new needs in nursing which the war will impose upon us—its terrible aftermath—and with these our training schools are deeply and vitally concerned.

The civil hospital schools have for months been making their best effort to meet the great emergency. Now the Army School has been called into existence to work not in competition with them, but as a new ally. And an alliance calls for understanding and effort on both

sides. We have, for instance, sent our million men to fight in France but we have depended upon the ships of our British allies to carry 60 per cent of them. The Army School will add greatly to the sum total of nurses who will be in training, will form a large part of our reserve power and will be ready before many months to reinforce the regulars wherever needed. And furthermore, the call of the Army School will be listened to by many of those young women whose understanding of life has not yet reached the heights which would enable them to see that our civil hospitals offer the same perpetual challenge to young womanhood for the service of the nation as do the army hospitals in war time. For in times of peace the student nurses in any hospital are working in some of the world's most ancient and as yet unconquered battlefields.

I think our civil hospitals may well be proud of their training schools. Any institutions which meet the crises of life as well and as nobly as our schools of nursing on the whole do, must stand among our cherished institutions and should be a matter of national pride. Their contribution to the country in this hour is whole-souled, genuine and dependable. As a recent observer in France says, "The American nurses are 100 per cent efficient." "The nursing is admirable," says another, "good, solid, skilled work." Colonel Finney, in discussing the situation with me recently, said that the country could well be proud of its army nursing service and of the quality of its work. He spoke particularly of the movable hospitals which follow the troops, and are so near the scene of action that nurses are and will continue to be under fire. This service he says is voluntary. But they all volunteer. There is no difficulty in getting them to go anywhere, no matter what is to be done. Thus far, therefore, our nurses have shown a high spirit of devotion and sacrifice. They have given unstinted labor and have nerved themselves to their great tasks, have heroically worked and heroically died. It is for us in whatever ways are fitting to pay our tribute to such women, and to help them keep up their fine morale.

May I venture here to say a brief word of tribute to the women at the head of our training schools? Some of the hardest sacrifices that have been made during the war have been made by these women working steadfastly at their posts, away from the public eye, trying gallantly to meet the new and continuous demands which the war has brought. They are bearing the burden and the heat of the day, and they deserve the fullest possible support from their hospital authorities and the public in the truly patriotic efforts they are making.

And may I say finally a word of the whole nursing situation and of those who have been struggling with its problems? War and its challenges are new to us, and most of us are not warriors. But our devotion to the best interests of the sick, whether under our care in military or civilian hospitals or in homes of any kind is, I know, single-minded and sincere. We have wanted them to have the best nursing care which we are capable of giving, and every step we have taken has been with that purpose and that hope in mind.

Social Service and Hospital Efficiency

By A. R. WARNER, M.D., superintendent Lakeside Hospital, Cleveland, Ohio.

We are all quite familiar with the word "efficiency," especially in its use to express the existence of an organization or process to secure maximum results through the expenditure of minimum time and effort. But what are

the ideal maximum results of a hospital's existence and activity? This must be established in order to determine the essentials of the best organization or process, or its efficiency. Of late the ideas about thorough, complete hospital work or results are changing quite decidedly and very rapidly, although this change has been marked in various ways and tempered by various viewpoints.

A single fundamental force, or a development of an idea or social principle, has caused extensive progress and change in practically all social organizations, of which hospitals are one, and also in all community work and routine. In recent years, this has also almost revolutionized relations between society as a whole and the individual. This idea is the recognition of the principle that the individual loss or gain is common loss or gain, that each individual is affected by and therefore interested in others, and that there rests upon society a right, a responsibility, and a duty, to protect itself and help the individual in need. This idea has invaded the hospital field, and under its influence hospitals, as institutions, have materially changed. The hospital patient is no longer merely professional material, or simply a sick man requiring professional treatment, but an individual to whom sickness has come to derange his entire living, all his service, and all his responsibilities, while others (at least his family) are caught in the misfortune. The patient and often the entire family are changed from an asset to society to a liability. It is recognized that all the damage is damage to the community and that there is not only a right, but an obligation, to interfere to lessen the loss. In these days we see posters warning us that every careless accident is a national calamity and all needless loss of working time, unpatriotic, indefensible, and inexcusable.

It is desirable and more efficient if all the work to be done between the incident of sickness and the return to normal life, together with the subsidiary problems, be handled, in so far as is possible, or at least correlated, by one institution, which shall be developed equal to this work. Although the proper development of the hospital, as such an institution, has not yet progressed very far, there is a decided tendency in this direction which is accelerating rapidly. The hospital is reaching out more and more from the narrow field of professional work to cover situations which certainly have more or less direct bearing upon the medical problems, and which have even greater bearing upon the problem of preventing individual deterioration and hastening rehabilitation. In this, the development of the hospital social service department has been the largest factor.

There are, however, other indications of this transition in the hospital as a social institution. There has been a decided tendency away from medical staff control of the entire institution, although a more complete control by each medical service or department head within the respective department. The principal of the training school has also come to have duties more definitely circumscribed by the requirements of her department. There is less of a tendency to control detail on the part of the especially interested supporter or active trustees, and a more general recognition by all trustees that the position is an important public trust and the proper discharge of its duties requires specific technical knowledge and experience. All the administration of the hospital dropped by these other departments has been taken up by the superintendent and made to count toward greater social efficiency for the institution. This has caused a necessity for more careful selection of superintendents, larger salaries, better and broader men, with the result that the number of medical men going into administrative work has increased.

Greater opportunity for constructive social work has proved an attraction. The arguments for the superintendent with medical training are obviously identical with the arguments for the hospital social worker with medical training.

It is, therefore, no longer sufficient to consider that simple relief to the patient's physical ills is hospital work well done, completely done, or efficiently done. The hospital has come to have a responsibility, which consists of playing its part, a large part, in helping to minimize all the damage from the sick individual and to repair that damage as quickly and easily as possible. In these days of failing man-power, the days of work missed either through illness or other causes has acquired an importance which we will not soon forget, and the existing trend to minimize loss through illness has thereby been greatly accelerated.

Here the best of medical service plays a part, but only a part. When it has done its utmost, there remains much which other means can accomplish, both as an aid to the medical work and independent of it. The chief torments of the average patient are not from the pain of his disease, but from the consciousness of inability to meet his or her responsibilities and obligations in life. It has been observed that hopeful, enthusiastic men, wounded in an advance, stand the shock of wounds better than tired, despondent, depressed men, wounded in a retreat. The work of the hospital as a modern social institution is then, primarily, to render every aid to the individual medical science can give and, secondly, to analyze the patient's individual responsibilities and the situation created by his temporary inability to meet them and, directly or through the cooperation which has come to exist between social agencies, to prevent deterioration and promote rehabilitation. The experience of the government in the rehabilitation of soldiers will become a guide for the future and will advance this work as nothing else could have done.

This nonprofessional work in medical institutions has come to be called Social Service, and its importance is secondary only to the medical work in the big problem of conserving human life and energy. The importance, the position, and the organization of the social service department in any hospital defines exactly the attitude of that hospital as a social institution toward the larger field. The number of paid workers may as yet also indicate the financial resources, but the organization of the department in the routine process of the institution is something apart from numbers. This nonmedical field is surely large enough to require an independent department, having the same relation to the administration of the institution as other essential departments.

Social service and hospital efficiency are, therefore, related in a double way. The contribution of social service to medical efficiency is no longer a question and consequently has not been discussed in this paper; for it is agreed that in this way, social service contributes indirectly to hospital efficiency. The larger contribution, however, is that direct contribution to the conservation of human energy which social service makes, not by aiding the medical work, but by direct service to the patient as an individual, to reduce the economic loss through him and his family and to hasten the return to full usefulness. As the medical work is the primary object of the hospital, so its proper accomplishment must represent more than half of the measure of the institution's efficiency. But as the ideal maximum results to be attained through the modern hospital have broadened and grown, the contribution which social service makes to hospital efficiency has increased in that same proportion.

The important work of the social service department, as outlined above, cannot, however, be well done by recent graduates of nursing schools or of schools of philanthropy. Not only is an understanding of the fundamentals of the medical conditions required, but a far reaching knowledge of sociology which will permit of rapid and accurate analysis, and also a mature judgment as to the best means to be used. This combination of talent is not now readily obtained, and a proper general development of hospital social service work must await the creation of means for producing personnel equal to the supervision in this important department. The question is now receiving some intensive consideration, and the universities have shown a desire to acquire and give the technical education demanded by this new field. The promotion and the development of these schools and their courses of training are worthy of every aid that the American Hospital Association can render.

HOSPITAL SOCIAL WORKERS HOLD FIRST GENERAL MEETING

Convene at Atlantic City in Conjunction With American
Hospital Association to Discuss Problems of Mutual
Interest—Program Presented

The American Association of Hospital Social Workers, held at Atlantic City, September 24 to 26, its first general meeting since its organization at Kansas City last May. The time and place were chosen to give the members an opportunity to attend at the same time the annual convention of the American Hospital Association.

War work in connection with hospital social work was the topic of most general interest under discussion. The programme on this subject included a report by Miss Jarrett of the Boston Psychopathic Hospital on the Smith College Training Course in Psychiatric Social Work, which is training workers to deal with war neuroses; reports by Miss Mary H. Combs of New York and Miss Ida M. Cannon of Boston, on social work under the department of Military Relief of the American Red Cross, in the army and naval hospitals, and a report by Miss Wadley of New York on the work of the Social Service Department of Bellevue Hospital for the children's year. Mr. Michael Davis of the Boston Dispensary presented the question of the relation of hospital social work to the Health Division of the Committee on Methods of Americanization, and aroused much interest in a plan of cooperation with the Association of Hospital Social Workers in the study of health problems of the foreign born.

The following resolution, which was adopted by the American Hospital Association in general session, is of great interest to all hospital social workers and seems likely to promote the progress of social work in hospitals:

Resolved, That the American Hospital Association express a recognition of a general need of a large number of women to supervise hospital social service work, who shall have the advantages of training by a university in preparation for such work; that the essential elements in such an education are (1) general educational; (2) medical; (3) sociologic; and that this work be so combined as to make a university course of reasonable length; and be it further

Resolved, That the executive secretary shall send copies of this resolution to such universities as do now give practical courses in philanthropy and sociology and to any other universities contemplating the establishment of such courses.

Emphasizing as it does the importance of a standard training, this resolution goes to the root of the business

before this generation of hospital social workers—namely, the building of a profession, and of one which shall be a real essential to the civilized community.

Report of Meeting of Representatives of Episcopal Hospitals

As arranged at the Cleveland, 1917, convention, a conference of representatives of the Episcopal hospitals was held in Parlor "C," Royal Palace Hotel, Thursday, September 26, 1918, commencing at 3 p. m., with the following present: Rev. F. R. Jones, chaplain Willard Parker Hospital, New York City; Rev. F. M. Crouch, secretary Social Service Commission, General Episcopal Church, New York City; Miss T. M. Jennings, St. Luke's Hospital, San Francisco, California; Miss A. M. Gaggis, Norton Memorial Infirmary, Louisville, Kentucky; Rev. John W. Walker, representing Trinity Hospital, Winner, South Dakota; Miss Florence M. Thompson, superintendent St. Luke's Hospital, Davenport, Iowa; Mr. Cornelius S. Loder, representing managing director Christ Hospital, Jersey City, New Jersey; Rev. Dr. Jeffrey, superintendent City Mission Society, Philadelphia, Pa.; Miss Hartry, St. Barnabas' Hospital, Minneapolis, Minn. Rev. Mr. Jones acted as chairman of the meeting, and Rev. Mr. Walker acted as secretary.

The object of this conference was to effect a closer cohesion among the Episcopal hospitals for the solving of their own problems, and for a greater interest in the American Hospital Association. It effected an organization in the appointment of a committee which will meet in New York shortly to draw up and map out a plan for the attainment of the objects of the conference. The men who have been asked to serve on this preliminary organizing committee are: Rev. F. R. Jones; Rev. Mr. Clover, superintendent St. Luke's Hospital, New York City; Rev. F. M. Crouch; Rev. Paul F. Swett, superintendent St. John's Hospital, Brooklyn, N. Y.; Mr. Cornelius S. Loder; Dr. Henry Barton Jacobs, Baltimore, Maryland; Sister Superior, superintendent St. Barnabas' Hospital, Newark, N. J.

It was the unanimous opinion of all present that there is a province for such a conference or committee as planned above, and it is urgently hoped that all Episcopal hospitals will endeavor to cooperate with the committee by sending answers to any communications they may receive from it, and also by presenting to the committee any problems they may have, which the committee may be able to solve for them, or in the solution of which they may be able to assist.

VACATION SHORE COTTAGE FOR NURSES

The Connecticut Training School of the New Haven Hospital Believes That Nurses Should Be Kept Physically Fit

By SIMON F. COX, M.D., Superintendent New Haven Hospital, New Haven, Conn.

Until recent years the life of a nurse in training, in contrast with the custom of today, was one of extreme drudgery. Today no hospital or training school manager fails to realize his or her position as an educator, and training schools are taking their place where they rightfully belong, namely, as a vital part of the hospital and essentially an educational unit.

With the awakening of hospital and training school boards of managers to their responsibilities comes the consideration of the needs for healthy bodies in the groups of

nurses. More attention is being paid in the planning of dormitories to the nurses' physical development, and we have the gymnasium, the tennis and squash courts, and various other devices under supervision of physical directors.

The training of a nurse is intensive work and study for a period of three years with but little break for recreation. And many a nurse receives her diploma on the verge of threatened broken health and is compelled to seek an extended rest before she can begin the practice of her profession.

Training schools should see to it that their recent graduates are physically fit and ready on graduation to take up their work. As an experiment to this end the Connecticut Training School for Nurses of the New Haven Hospital of New Haven, Connecticut, provided a seashore cottage for the use of the nurses. This cottage is open from May 15 to November 1. Search was made for a suitable seaside cottage which should be close to the city and sufficiently large to permit at least one dozen nurses, a housekeeper, and a maid to sleep there. It should have an adequate kitchen and dining room to feed twenty-five nurses. There should be a plot of land sufficiently large to give seclusion, and, in addition, a private bathing beach. We felt these provisions would serve the training school of



The seashore cottage provided by the Connecticut Training School of the New Haven Hospital for the vacations of its nurses.

a hundred pupil nurses. Happily a secluded cottage on a three-acre plot with a private bathing beach was found in Woodmont, close to a trolley line. This house was rented and furnished with standard nurses' dormitory furniture and formally opened with a resident housekeeper and a maid.

It was planned to furnish for such nurses as remained over night a substantial breakfast. Other meals were of the cold variety and consisted of cold meats, salads, etc.

Supplies were sent daily from the hospital, the meats and such things being cooked in the hospital kitchen.

The night nurses slept in the cottage during the whole summer and could easily have their dip in the ocean, eat supper and return in plenty of season for their night work. Week end and even vacation periods are spent there with profit by the nurses.

We were interested to note the general health of the nurses during the following winter as compared with other years and we were not surprised to find that the number of days lost by sickness had been decreased over 40 percent.

LETTERS TO THE EDITOR

Work in Chinese Women's Hospitals

To the Editor of THE MODERN HOSPITAL:

Your letter of March 11 arrived some time ago, while I was very busy nursing one of the men of the mission. I returned to the city on Tuesday of this week from the university campus outside the South Gate.

As you probably are aware, we newcomers have to have two years language study, helping in some work the second year, to get a better working vocabulary than one would get from books. Some of the translations of our

servation of women's and children's diseases. And the babies and children need care, oh, so much! In West China it is estimated that from 85 to 88 percent of all babies die before they reach their second birthday. Do you wonder that Dr. North of our Mission Board in New York before I came out asked me to work especially along infant welfare and prenatal care lines? And the children are loving and lovable. Babies and children are the same the world over.

During February our hospital was crowded with wealthy families who had come in to protect their growing daugh-



Fig. 1. Methodist Men's Hospital, Chengtu, China

American nursing text books are in Gwan Hwa, or official language, more of them in "Wen li," or very high literary style, while the people use "Tu Hwa" (earth words); so you see what a problem we have here, just in the language. The year I came out, two of our West China physicians had to return to America; so we have three closed hospitals, two in Chungking and one in Chengtu. It is no doubt fortunate for me that the hospitals were closed, for, if they were open, I probably would have had very little time, if any, for language study.

We feel that the Chengtu hospital should be opened first to afford a place for clinical work for the students in the medical school of the West China Union University. There is a men's hospital operated by the Canadian Methodist Mission, but, so far, there has been no place for ob-



Fig. 2. Calling for Medicine, Chengtu, China

ters from the ill designs of the southern soldiers. One afternoon in the hospital chapel I told the women and their serving women about the care of new-born babes—especially, of the care of the cord to avoid tetanus (thousands of babies die in Chengtu each year from tetanus, due to the use of dirty, rusty scissors). While I was talking the husbands gathered about the outer door to hear about their babies. After that the men and their wives brought their babies each day and, where they needed a doctor's advice, I had Dr. Canright see the babies and order what was necessary. Very often the advice needed is more about cleanliness and feeding.

Under separate cover I am sending a report of the Chungking Women's Hospital, which is closed, as Dr. Ed-



Fig. 3. Dressing Sores, Chengtu Beggar Reformatory, West China

monds, dearly loved and respected, is in a tuberculosis sanatorium in Los Angeles. There has been no one to take her place; so this wonderful opportunity is being lost. Our hospital here has been closed since before I arrived.

In regard to our helpers, for two years there will be no graduates in medicine. Aside from the physician and nurse in charge, all other helpers must be taught and trained. Owing to Chinese ideas of propriety, a woman nurse can not go into a man's room; so it is necessary for

men's and women's hospitals to be separate, with male nurses for men and women nurses for women.

The patients coming now to the dispensary are rich and poor, high and low. One day recently there were fourteen officials' wives.

I feel that this is a very rambling letter, but, as soon as I can get into work, I shall be glad to write about adaptations of home methods to Chinese conditions. However, during this past year, Szechwan has been torn with dissension, and Chengtu has had two long sieges of shell fire and burning. Chengtu was a city, according to Chinese history, when Abraham started to seek the Land of Promise. Marco Polo visited Chengtu in his day. It was capital of one of the three kingdoms during early history. It is now capital of this vast province, the richest in China.

BEATRICE W. MURDOCH,

Chengtu Hospital, West China Mission, Methodist Episcopal Church,
Chengtu, West China

Associated Purchase Method Adopted by Australian Institutions

To the Editor of THE MODERN HOSPITAL:

It will interest you to know that the method adopted by the principal public institutions here in connection with the purchase of their main requirements is to work on the basis of associated purchases. Our institutions are supported by public subscriptions and also by grants of money from the government of the state. Each institution in the past looked after its own purchases, and it was found through various causes that for common requirements such as bread, meat, and drugs certain institutions were paying very much more than others. It was felt by the governing bodies, that, as far as the public charitable medical institutions were concerned, the policy of combining quantities for contract and direct purchase would enable stores of various kinds to be purchased in larger quantities (including drugs, drapery, meat, bread, etc.), and thus enable the lowest supplying price to be secured. The Hospitals' Board of Supplies was therefore established, employing a secretary, and having on the board one representative from each of the main institutions concerned. The plan has worked out favorably where definite standards can be arrived at.

It is obviously simple enough to establish a standard for bread, and by combining orders for one or other of the larger institutions we can certainly do better in our purchases than if we purchased for each institution individually. We standardize requirements in bedding and drapery, and with us drugs are naturally standardized on the British pharmacopoeia basis. We are certainly able to buy most of our commodities at better prices than traders because we go as near as possible to the fountain head, or original supplier. Besides this, we claim that in our purchases we are not competitors with traders, for the reason that we do not distribute our goods amongst the public, and, consequently, our claim to purchase on the best possible basis has become recognized.

In a general way the foregoing explains our system.

We have in addition instituted a series of meetings which prominent officials, such as secretaries, matrons, medical superintendents, etc., can attend and discuss important subjects such as hospital provisioning, efficiency and economy, utilization of wastes, and also subjects such as the testing of articles with a view to ascertaining the best standards which will give the greatest economy in working.

We have in anticipation lectures on modern hospital building, lighting, airing, and such other subjects as are akin to the interests involved.

The main point, however, with regard to our particular department of work is the business end of the hospital as distinct from the scientific and professional side. Most of the members of our board are business men, and their experience is certainly of great value to the institutions concerned.

I am engaged in business in this city and I think I am correct in stating that this in itself was one of the special qualifications required in the secretary in view of the purpose for which the board has been established.

For the HOSPITALS' BOARD OF SUPPLIES,

W. H. MACLENNAN, Secretary.

Melbourne, Australia.

Work of the American Woman's Hospital in France

To the Editor of THE MODERN HOSPITAL:

Things are happening rapidly in the American Women's Hospitals. We have established a military hospital, the first to be established by American medical women in France.

As noted in the article I wrote for you, which was published in your July number, we started to establish a small civilian hospital in the department of the Aisne, with Dr. Barbara Hunt, of Bangor, Maine, as director. As soon as we had taken possession of the château in Neufmoutiers, placed at our disposal by the devoted and charitable French owners, we were asked to double the beds in this hospital, and before we were able to do even this, the commandant of the Sixth Army Corps asked us to establish a military hospital of one hundred beds just behind the lines, which should be expandable. This we have done.

I believe this to be the beginning of a series of military hospitals which we will establish. Just now our Dr. Purnell, accompanied by a staff, is sailing for Europe with an idea of inspecting this hospital and making a general survey of the medical situation in France.

CHARLOTTE M. CONGER,

Executive Secretary, American Women's Hospitals, New York.

BOOKS RECEIVED FOR REVIEW

The Treatment of War Wounds. By W. W. Keen, M.D., LL.D., Major, Medical Reserve Corps, U. S. Army, Emeritus Professor of Surgery, Jefferson Medical College, Philadelphia. Second edition, reset. Cloth, pp. 276, illustrated, \$2. W. B. Saunders Company, Philadelphia, 1918.

How Shall I Take Exercise and Set-Up? A Physician's Analysis of the Why and Wherefore, What's What, and What's Worth While in Exercise, with illustrated movements. By Samuel Delano, M.D. Cloth, pp. 135, illustrated, \$2. The Four Seas Company, Boston, 1918.

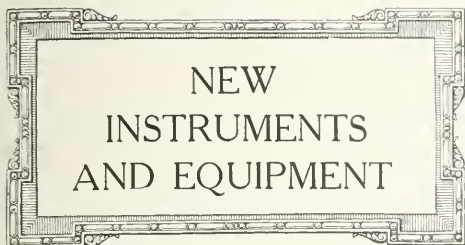
The Hospital as a Social Agent in the Community. By Lucy Cornelia Catlin, R.N., Director of Social Service Work and Executive Director of the Out-Patient Department Youngtown Hospital, Ohio. Cloth, pp. 113, illustrated, \$1.25. W. B. Saunders Company, Philadelphia, 1918.

Reclaiming the Maimed, a Handbook of Physical Therapy. By R. Tait McKenzie, M.D., Major R.A.M.C., Professor of Physical Therapy University of Pennsylvania. Flexible leather, pp. 238, illustrated, \$2. The Macmillan Company, New York, 1918.

Report of the Department of Health and Sanitation of the City of Seattle, Wash., embracing the work of the department and the vital statistics for the calendar year 1916.

Everyday Foods in War-Time. By Mary Swartz Rose, Assistant-Professor, Department of Nutrition, Teachers College, Columbia University. Cloth, pp. 117. 80 cents. The Macmillan Company, New York, 1918.

All persons interested in the collection of fruit pits are urged to help facilitate the packing and shipment thereof by drying them thoroughly.



VINCENZ MUELLER, Technical Editor.
GEO. W. WALLERICH, Associate Editor.

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast avenue, Oak Park, Illinois.

Knitted Gauze Dressings

How to conserve and re-use surgical dressings over and over again, is one of the most important questions which confronts our hospitals today.

A step in the right direction toward solving this problem is the method of preparing surgical dressings developed by the Re-Use Knitted Gauze Company, of Kankakee, Ill., in conjunction with the Surgeon-General's Department. Thorough trials in several base hospitals in this country have convinced the authorities that the use of these knitted dressings of various shapes and sizes is so satisfactory and economical that it will result in the release of large quantities of gauze for our forces abroad.

Re-Use Knitted Gauze Dressings are made from high-grade cotton, knitted in tubular form and finished in various shapes. They are highly absorbent, soft in texture and when properly reclaimed can be used indefinitely. They are to be applied in hospital and surgical work exactly as woven gauze, and the manufacturers claim that the cost of surgical dressings in a hospital can be reduced by several hundred percent, depending upon the care with which the process of reclaiming is carried out.



Fig. 1. Piece of knitted gauze folded making an ideal sponge.

The knitted gauze can be folded for use as compresses or pads, and is made in a number of sizes, such as 4 by 4 inches, 6 by 8 inches, etc. Absorbent pads 8 by 12 inches and 12 by 24 inches, as well as abdominal rolls, are also furnished, and the material is knitted into various shapes for use as head covers to keep scalp dressings in place, for surgeons' operating helmets and ward masks, and for use in isolation wards, as well as in tubular form for use under plaster casts.

We thoroughly believe that it will be well worth the time of every hospital manager to investigate this proposition, both from the point of view of cost, as well as on account of the great saving of labor that will result from using indefinitely these prepared pieces of sponges, pads, etc.

Parallax Foreign Body Localizing Instrument

This instrument, which was devised by Capt. E. S. Blaine, M.R.C., makes use of two well-known principles of foreign object localization with the x-ray, the "parallax" and the "double ring." The feature of the instrument is in the three direct reading scales graduated in quarter centimeters, which give the depth of the projectile below the upper skin surface, the height from the under skin surface and the distance laterally from the skin at the level of the object. The under and side points are conveniently marked on the skin by pressure plungers which actuate inked wicks.

The principle of the parallax is that the shadows of objects at different distances from a source of light will move at different speeds and distances in accordance with the moving of the light parallax to the plane of the surface upon which the shadows are projected. Thus the closer the object to the light the greater will its travel be. Therefore, if two objects are at the same distance or level, their speed and distance of travel will be identical. By this means one obtains the exact level at which two objects lie. If one can measure one of these it follows that the other is at the same level or depth.

The double-ring principle is that of two rings directly superimposed and in line with a third object between them; their centers will represent the true vertical line upon which all three lie. Substituting the x-ray for the source of light, the same conditions will be obtained, and, if the inlet and the outlet of the vertical ray be marked on the skin, we have the line upon which the foreign object lies, regardless of rotation of the part.

The operation is entirely fluoroscopic, thus doing away with the need of plate exposure and consequent developing and delay due to the handling of the plate or film.

The instrument consists of an aluminum base, containing arm and brass ring with skin-marker in its center concealed in the body of the base, an upright post which carries two horizontal arms, the upper one having a ring set exactly above the one in the base, the lower of the two being the parallax arm. This arm is a square tube graduated on its upper face in quarter centimeters, indi-

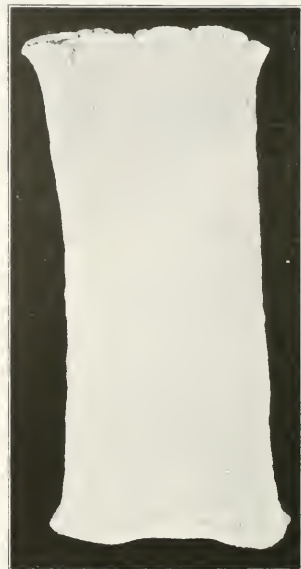
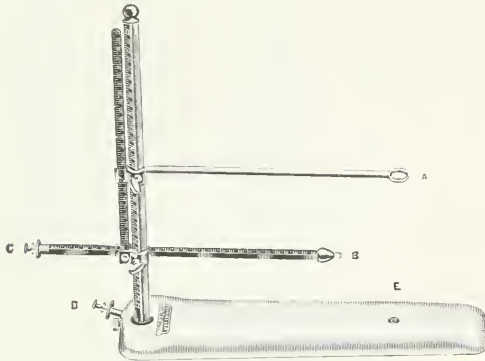


Fig. 2. Finished piece of knitted gauze before being folded into sponge.

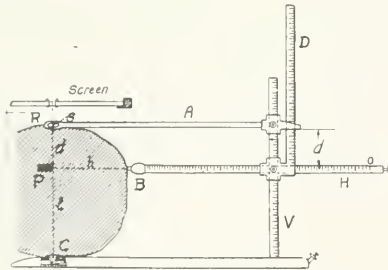
cating the distance from the center of the rings. The tube also contains a push rod with a skin marking wick at the end, which is saturated with special ink. This



Parallax foreign body localizing instrument.

arm is adjustable vertically on the upright post, and horizontally on a sleeve on the same collar, on the post. The upper rod is adjustable vertically only, both the upper and lower rings being fixed in position. The patient is examined for the approximate position of the foreign object, after which the base of the instrument is carefully inserted under the part, and the rings placed as near to the vertical plane of the projectile as possible, and the upper ring is just above the upper skin surface with the parallax rod drawn back, so as to allow the free movement of the instrument.

Under the x-ray the instrument is moved, the two rings being exactly superimposed on the shadow of the projectile. A sheet of clear celluloid, ruled in parallel lines, is placed on the skin surface with one of the rulings in line



Method of reading the scale.

with the shadow of the arm of the instrument. The x-ray tube is then displaced to right or left until the shadow lies on the same line, the parallax rod is raised or lowered until the middle of the shadow lies on the same line as the shadow of the projectile. The upper ring is lowered until it touches the upper skin surface, which is marked with indelible ink and the parallax rod is moved forward until it touches the skin, when the plunger is depressed and the skin is thus marked on the side on a level with the shadow of the projectile. Then the plunger, which is concealed in the base and to which is attached an articulated arm or hammer with inked wick, is pushed forward, which causes the skin to be marked in the lower center of

the ring. The operation is now completed, except for reading the figures.

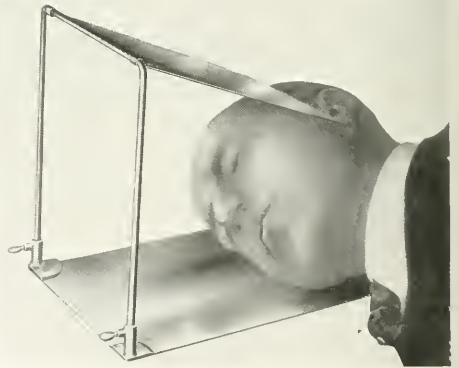
The scale is read in the following manner: "A," the depth from skin above to the projectile on the left hand vertical scale; "B," the height from skin below on the right hand vertical scale; and, "C," the lateral distance from the side skin mark on the scale on the parallax rod. The three resulting ink marks on the skin permit the surgeon to choose any one of the three routes of approach to the foreign object; he will be guided by the anatomy of the region as well as the surgical indications.

This instrument is one of the several standard methods adopted by the U. S. Army Medical Department for use in projectile localization, and all student officers in the course of instruction in roentgenology are being trained in its use and application. It is stated that the degree of accuracy with which this instrument locates projectiles, leaves but little to be desired and that it is seldom that the foreign object is found more than 1 or 2 mm. off from its true location in the tissues.

Anesthetic Screen

This device, as designed by Dr. E. B. Dench, New York, is intended for use during mastoid operations, in order that the operator and anesthetist may have separate and distinct fields for their work.

After the patient has been put under the anesthetic, the lower plane of the apparatus is slipped under the rubber



Dench anesthetic screen.

pad or cushion supporting the head. The two posts which support the upper plane are inserted into the binding terminals and the entire apparatus adjusted so that the free margin of the upper plane lays on the patient's temple just in front of the ear. A sterile sheet is then draped over the top and on the sides, so that the operator is afforded protection from the fumes of the anesthetic, and the anesthetist has a clear view of the patient's face, which, together with the anesthetizing apparatus, is isolated from the field of operation.

The upper plane of the apparatus also forms a handy resting place for instruments when not in use. The device can be folded into a compact form so that it may be easily transported in the surgeon's instrument bag.

Dr. W. W. Keen, of Philadelphia, states that anti-typhoid vaccination has practically banished typhoid from the camps at home and the armies in Europe.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XI

November, 1918

No. 5

AT THE SIGN OF THE BLUE CROSS

What Is Being Done for the Horses on the French and Italian Fronts—Methods of Treatment in the Blue Cross Hospital

By CHARLES W. FORWARD, EDITOR, ANIMALS' GUARDIAN, AND GEORGE FREDERIC LEES, LONDON

THE entry of the United States into the great struggle on the battlefields of Europe for the freedom of the world has quickened public interest on both sides of the Atlantic in the welfare of the horse. What is being done to reduce the sufferings of our equine friends who have been called upon to share our burdens?—is a question that everyone who is a lover of animals (and who is not?) is asking. It is, indeed, an important question, one in which Americans are specially interested, considering the very large number of horses that will be required by the United States before the war is over and the many thousands of valuable animals that must of necessity come from the New World. It has been calculated by a well-known American journal that the United States Army will require one horse to every four

men. An army of four to five million men has been spoken of as necessary. If that be so, what a vast army of horses we shall have on the various battle fronts before the day of victory dawns!

Horses, like men, quickly fall sick and grow "war-weary." Scourging diseases are lurking all along the path of the gallant horses and mules which, in tens of thousands, have assisted the soldiers of the entente powers to gain victory. Only those who, like ourselves, have been at the front, can realize the horror of such dreaded scourges as sarcoptic mange, due to constant work in mud and attendant exposure to the icy winds of winter.

Many people believe that the horse is a robust animal and will stand any amount of rough usage and bad conditions of life. Never was there a



Fig. 1. Receiving station at a typical Blue Cross hospital in France.

greater mistake. The horse is indeed most susceptible to illness. He easily catches cold and gets a fever. Respiratory troubles easily get a grip of him. Fortunately, this fact is well known among the officers of the veterinary service of the armies, and all sorts of precautions are taken, as soon as horses are landed from England, to protect mounts from coughs, fevers, catarrhs, pneu-



Fig. 2. Army surgeon extracting shrapnel splinters from a horse with fractured hip-bone and draining the wound.

monia and pleurisy—and with marked success. We are glad to say that these ailments are comparatively slight among horses at the front.

Notwithstanding, already the suffering among war horses has been terrible. It was calculated some little time ago that, leaving Mesopotamia and Africa (except Egypt) out of consideration, more than 250,000 horses had died, while, in addition, over 30,000 had been sold owing to age and disease. No fewer than 33,000 animals were reported to have died in America whilst awaiting shipment, whilst 6,000 died at sea. That is to say, nearly 40,000 horses purchased for military purposes never became available. Apart from the humanitarian standpoint, there is here a loss that cannot be tolerated. We must husband our forces in horse power as in man power, and see that everything is done to relieve the sufferings of those dumb creatures whose aid we are employing for the benefit of humanity.

Just now, during the great fight which is taking place in France and Flanders, horses are having a great deal more work to do than they had during trench warfare. What is happening to them? One of the writers, who has just returned from the front can answer this question in the form of a little *chose vue*.

The incident he observed occurred not far from Mareuil. A body of dragoons were on their way to hold up a German thrust and they came under heavy shell-fire. Many of the horses were wounded and their riders, thrown to the ground, were under the painful necessity of abandoning

their steeds. The duty of these soldiers was clear. They could not leave their animals to die a lingering death, so, drawing their revolvers, they proceeded to put them out of their misery. It was one of the most touching sights imaginable. Many of these men had tears in their eyes; some even turned their heads away as they pulled the triggers. That was to avoid the look of wondering reproach which the poor beasts turned on their masters. But there was nothing for it but to end their misery in that way; they were too badly torn in flank or belly by fragments of shells to make it possible to remove them to the hospitals of the Blue Cross.

These Blue Cross hospitals in France are doing a most magnificent work. They are the outcome of a fund started in 1912 by "Our Dumb Friends' League," a London society for the encouragement of kindness to animals, the president of which is the Right Hon. the Earl of Lonsdale. The president of the Blue Cross Fund (58, Victoria Street, London, S. W. 1.) is Lady Smith-Dorrien. The hospitals are situated at Moret (fifteen wards), St. Mammes (five wards), Provins (seven wards), La Grand Romaine, and Favière. The material organization of these depots is always the subject of the greatest attention, the rules presiding over their installation being first of a hygienic and secondly of an economic order. The premises, altered according to needs, include comfortable



Fig. 3. Diagnosing a severe shell wound in the shoulder of a horse.

stables with plenty of light and air. The ground is laid in such a way that hygienic cleaning is rendered easy and efficacious; it is slightly sloping backwards, so that the liquids may quickly run off; and the ground is always covered with a plentiful litter, renewed twice daily. Oats and other food are distributed in stone or stick board mangers, located low enough to allow the horse to feed in the normal horizontal position of its entire spine. The greatest attention is paid to grooming. Drinking water is from streams running close by the stables; its good quality has

been proved by chemical analysis. In the neighborhood of the depots are large natural meadows, in which hospitalized horses can graze freely, with the benefit both of green pasture and of beneficent exercise in open air.

With the exception of St. Mammes, the organization of each depot is identical. It includes a surgery and a pharmacy room, inside the largest hospital, where are grouped all the injured horses requiring serious operations and constant care. A second hospital is exclusively devoted to sick horses, and these are in very limited number. Contaminated animals are thoroughly isolated in special places. This category is chiefly composed of mangy horses, other catching diseases being practically unknown, thanks to the prophylactic measures taken by the veterinary military services and by the technical service of the Blue Cross. Lastly, to each depot is annexed a simple farrier's shop.

The specialty of each of the above named hospitals will be seen from the following table:

MORRET

Birmingham Ward—Horses in good form.

Margaret—Suspected, isolation.

Huddersfield—Surgery and pharmacy.

PROVINS

Alexis Ward—Surgery and pharmacy.

Victoria, British Columbia, Ward—Gravely wounded and over-ridden.

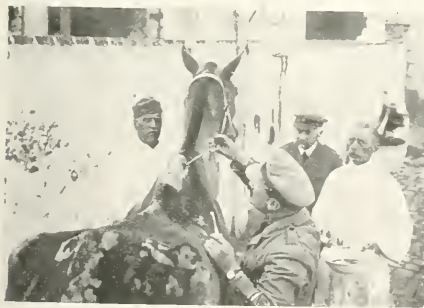


Fig. 4. Irrigating and disinfecting a wound on the horse's neck.

Ogden Ward—Parasitic diseases.

Tornau, Great Amwell Branch—Wounded, overstrained.

Ste. Colombes, Hartley Wintney—Lameness, fatigue.

Fleet—Knocked up.

Philadelphia—Surgery and pharmacy.

Post Card Guild—Parasitic diseases.

STE. MAMMES

Edith Cavell Hospital—Epizootic lymphangitis.

Parasitic diseases, such as skin itching, have exacted a considerable effort from the veterinary surgeons and workers of the Blue Cross in France, and greatly delayed the return to fitness of the

sick horses. But the veterinaries have remained masters of the situation, and for the present this disease has disappeared from the depots. As to internal illnesses, we can state they hardly exist, thanks to good hygienics.

As the manager of the veterinary service to which the Blue Cross belongs has reported to the society in London, "these depots are remarkably



Fig. 5. Probing a bullet wound on withers.

well kept and the results are excellent. Nothing but congratulations can be addressed to the manager and to the veterinary practitioners. At the present time five thousand horses have been provided for by the Blue Cross in France, and sent back to their duties."

We were told by the veterinary surgeons of the Blue Cross that the two most serious troubles they had to contend with were mange and other allied skin diseases and ophthalmia. The former is essentially a winter disease, and as one of us was in France during the snowy weather he saw a number of very bad cases, which were all cured by the well-known dipping method. There are three forms of mange, sarcoptic being by far the worst. The parasite burrows under the skin, where it lays its eggs and thus produces a most horrible and painful eruption. As a precaution against germs harboring in the horses' coats, these are cut before the advent of the cold weather—namely, in October and November. Nevertheless, our four-footed allies succumb to the dread disease, patches of which you will generally see in the region of the mane, neck and withers. Formerly, the treatment used to be dressings of sulphur ointment; but now, as previously mentioned, dipping is the method employed. In brief, the mangy horse is given a bath in a heated fluid of calcium sulphid. This bath is in the shape of a long and deep well and is part of the essential equipment of every up-to-date hospital in France. The patient passes in at one end, down an inclined plane and must perforce plunge into the dip, after which he struggles out

at the other end. This treatment is repeated a number of times. Two months may be necessary for his cure. Good feeding and careful grooming, of course, do much toward turning him into a healthy animal again.

French veterinary officers adopt another method. They have an installation for treating many horses by means of sulphurous acid gas (SO_2) during two hours at a time. They are put into chambers, with only their heads protruding into the open air. But we cannot say as to whether this treatment has been found really practical.

General debility is another of the ills to which horseflesh is heir. Under the conditions of



Fig. 6. Extracting a projectile from a horse's hoof—a most delicate operation.

modern warfare, it is not always possible for our men to prevent the horses sinking to too low a condition. How many advanced cases have we seen in the depots of the Blue Cross! It must also be remembered that the war has lasted four years and that these have been added to the age of our four-footed soldiers. It has been estimated that about 10 per cent of the animals passing into our hospitals are fifteen years old and over. We have always made a point of pressing this fact in official circles, where it is often forgotten that it is poor finance and by no means good policy to keep these horses any longer in the army. What happens to those animals that are discharged? Many of them go back to the land and help the old men, the women and the children of "la belle France" to cultivate the ground. It gives one pleasure to think that they will be well looked after and will live under the healthiest conditions for the rest of their lives.

But let us continue to speak of other diseases which the veterinary surgeons of the Blue Cross hospitals have to combat. We have already mentioned ophthalmia. Iridocyclitis is the form most prevalent in France. Its cause is unknown, but it is doubtless due to errors in feeding, exposure, irregular exercise, and a low vital condition. A

point to be mentioned is that horses from the United States that have been fed on cottonseed are very subject to the disease. Treatment in our hospitals is the same as in those of the ophthalmia veterinary hospitals of France: a hypodermic injection just above the eye.

Microbean diseases are very common among horses. Take the case of ulceritic cellulitis as an example. If it attacks the kidneys, "No remedy!" says the veterinary, and the poor animal must be destroyed. But if it only just enters the skin and causes a running ulcer, then the disease, thanks to the progress made by leading bacteriologists, can be fought and conquered. Out of 1,867 cases which were treated between January and October of last year there were nearly six hundred cures. But the percentage has since been much greater.

We need say little as regards the treatment of horses for wounds. It is practically identical with that given to the soldiers suffering from shell-splinters, shrapnel bullets, and bomb splinters.

A well-known authority whom one of us met in Paris gave us some very interesting official figures concerning the horses and mules that have been in the firing line. He said that no fewer than 551,960 horses and mules had been admitted to the hospitals and convalescent depots in France from the beginning of the war until February, 1916, and of these 394,768, or 71.5 per cent, had been cured, leaving 34,327 still under treatment. During the same period 16,215 died; while 106,650 had to be destroyed or sold. Eloquent figures indeed, for they prove how very efficient our hospitals, both official and private, are and how great have been the strides made by veterinary science since the wars of the past.

Splendid support has been given to the Blue Cross by the Dominions, and substantial help has come, too, from the United States, where Mrs. Ellphinston Maitland has acted as representative for the Blue Cross with marked success.

One of us, on the occasion of a tour of inspection of these well-equipped hospitals, was also most favorably impressed with the appearance of the horses under treatment. He found they were suffering from a variety of injuries, one of the most common being saddle-sores. It seems that the saddles, once put on, are seldom removed under war conditions and, as they do not always fit, unequal pressure causes large surface wounds. On the saddle's being taken off, a portion of the wretched animal's skin often comes away with it. This is a difficult injury to deal with. Thorough cleaning of the wounds and the application of petrolatum dressing brings about a healing of the surface, but the new tissue is extremely delicate.

Such horses ought never to be used again as mounts, but only for transport work. There were other cases of horses with shell and shrapnel wounds. A large proportion, however, were more or less broken-down animals, requiring merely careful feeding, grooming and rest. What sorry beasts these last-named were! A group arrived at the depot at the same time as one of the writers. The change when he next visited the hospital, not more than three weeks later, was marvelous to behold; he could hardly recognize them as the same animals. They had arrived in such a state that they could hardly drag one leg after the other; now they were frolicking around the paddock, enjoying the crisp air (it was winter time) and the warmth of the noonday sun.

The Blue Cross has also done splendid work in Italy, which one of us visited when that country was about to declare war. The visit in question was in reference to the organization of a hospital service for the Italian Army. The Blue Cross Fund Committee voted a sum of 25,000 lire (5,000 dollars) to the Italian Croce Azzura, and a further sum of over one thousand dollars was subsequently sent to help the Italian horses. A third donation of 25,000 lire was sent by the London committee, telegraphically, on hearing of Cadorna's set-back.

In regard to the treatment of wounded horses the Italians have been dreadfully handicapped. As our readers will remember, the outfit purchased for Lord Astor's hospital was captured by the Germans at the time of their invasion of Italy and the Italian army was placed at a grave disadvantage. Hence the necessity of doing all we can to help forward the cause not only in France but in Italy, where the work of the British Blue Cross is highly appreciated. On the journey from Rome to London one of us heard this good news repeatedly from the lips of French and British officers.

The Blue Cross Fund has received over 100,000 pounds (500,000 dollars) from all parts of the world where Englishmen and lovers of horses are to be found. And we should like this further fact to be known all over the United States, namely, that the Blue Cross is the only organization with hospitals under its own control and independent of the army, though working with it.

This money has been expended not only in the upkeep of the various hospitals, treatment, etc., but in the purchase of veterinary requisites and horse comforts. Who has not heard of the "Blue Cross Veterinary Chests"—those handy, portable chests containing a carefully selected supply of instruments, bandages and rugs most frequently needed in giving relief to wounded and sick horses,

far removed from the base or field dressing station? Moreover, money has had to be spent for thousands upon thousands of bandages, wither and sheepskin pads, ointments and drugs, portable forges and clipping machines, chaff cutters and poultice boots, pocket veterinary cases, special waterproof rugs for winter use, canvas water troughs, and fomenting pales.

How many thousands of letters have been received at the London headquarters from the grateful army officers! "Many thanks for the grand lot of stuff you so kindly sent me from the Blue Cross," wrote one cavalry officer. "I can assure you it was most useful and most acceptable." "I have today received," writes another,



Fig. 7. Searching for a bullet in neck of wounded horse.

"a hamper containing liniment, iodine, boracic ointment, and powder; also a day or two ago, a pair of leather poultice boots. I very much appreciate the good work your Fund is doing."

May we be allowed to say a few words in conclusion regarding another branch of the work of "Our Dumb Friends' League,"—the special attention which is being devoted in France to wounded and sick dogs of war? A hospital has been founded for these devoted four-footed allies. The wonderful service that dogs of certain breeds have rendered the French soldiers has at last been recognized by the British authorities, who have started the training of sentry and messenger dogs, etc., on serious lines. Appeals are being made to dog owners to contribute suitable animals for war work. This appeal for dog-power must, of course, be followed by the establishment of dogs' hospitals. Here is a branch of work which will have to be developed by the Blue Cross of Great Britain!

I count that Investment most profitable which pays me in dividends of Friendship. Money and position and power are all valuable and may be of great service, but none of these yields so great a rate percent of Happiness as my investment in human kindness and human service out of which grow human friendship.—E. O. G.

THE EDUCATIONAL WORK FOR CHILDREN AT LAKESIDE HOSPITAL

Need for Educational Advantages for Children in Hospital—Americanization of Foreign Patients—Organization of Educational Work in Lakeside

BY A. R. WARNER, M.D., SUPERINTENDENT, LAKESIDE HOSPITAL, CLEVELAND, OHIO

WITH the development of the social service idea there has come to many hospitals a feeling of responsibility to patients which demands that the entire welfare of the individual be considered, served, and promoted. It is no longer sufficient to receive patients without consideration of why they are ill, to use them simply as clinical material, or to make statistics, and then to discharge them without a thought of their present facilities for convalescent care or regard for their future welfare. As a part of the broad principle of responsibility to society and to the individual patients, educational opportunities for children received due thought and consideration, for in a child mental development is second only to health.

The beginning of the educational work in Lakeside was the foundation of the Page Kindergarten Fund. This was a fund given by Mr. and Mrs. E. S. Page in 1903. The income of this fund was to be used for kindergarten supplies. It was then thought that the kindergarten teachers would continue to be volunteers. The fund was larger than necessary to furnish the supplies used and the income accumulated. At this time Mrs. Frank P. Smith was the chairman of the kindergarten committee. Mrs. Smith became convinced that better work would be done by paid kindergarten teachers. In order to try it out, she employed a paid kindergarten teacher and the better results were demonstrated. Since this time one paid teacher has been employed regularly. Volunteers have merely supplemented regular work, and their activity has at all times been under the direction of the paid teacher.

As the kindergarten work developed and its value for younger children became apparent, the need for corresponding work for the older children became appreciated. There was need for diversion to lessen the burden of hospital life to the convalescent child; there was need also for systematic instruction to produce the natural mental development which is the right of childhood. At first an extension of correspondingly interesting and entertaining work, adapted to the age of the child, was attempted by volunteers. This work did interest and make the hospital residence happier for the children, and was to a certain extent developmental. It did not, however, meet one sad result of prolonged hospital

stay. We had learned that many children, particularly difficult orthopedic cases, after a stay of a month or so in the hospital, fell behind in school work and, especially if the absence was in the latter part of the school year, failed to pass into the next grade. We had learned that such tragedies were likely to happen several times in the education of the same children. The same pathological condition which caused the one hospital residence often caused others. The result was that in severe cases, such as bone tuberculosis, children lost several grades in school, became older than their classmates and thereby developed a dread of school attendance that seriously hindered their progress. Many of them dropped out of school for no other reason than that they had become ashamed of their grade, ashamed to be graded with children who were so much younger. These cripples are the children who, above all others, should receive education. With an education there are many vocations in which a cripple can excel and many others in which he may successfully earn a livelihood and be free like other people. Without education the life of a cripple is indeed hard.

This situation was called to the attention of the Board of Education of Cleveland. The work being done in the hospital was investigated and approved, but the fact was recognized that this work was not meeting the situation—that it did not prevent the loss of school grades. Interest in the problem was aroused, and, as there were in the hospital at all times enough children to occupy the time of one teacher, the board decided that these children were entitled to the same educational facilities as their more fortunate fellows. A grade teacher was therefore employed to begin work January 15, 1918. This teacher is a part of the teaching force of the public schools, familiar with the grading and the work of each grade, and familiar with the time of year in which each topic is taught. She is attempting to keep up the work of each child so that it may go back into regular school life without a handicap from long absence. It is too early to state positively the result of this work, but it now seems to be working out successfully.

This innovation happened to come at the time that the board was planning extensions to the work of Americanization. A second teacher was

therefore sent to the hospital from this branch of the work. It is the duty of this teacher to teach convalescent men and women to read and to write the English language. Most of these patients have had some education in their native land, so that the task is a much simpler one than teaching a child. Progress is very rapid and the interest in the work shown by the patients is simply astounding. To see a group of grown men struggling with the fundamentals of arithmetic, or writing sentences so simple as to be childish, is pathetic. It makes one realize that we have talked too much about the duty of our foreign population to this country and too little of the responsibilities of this country to these foreign-born citizens.

It will be difficult to measure the success of this work, but we believe that, if the beginnings of an education to write, read, and speak English

are obtained and the determination to finish the task aroused, many, if not quite all, will in various ways continue their development after leaving the hospital.

The organization of the work is as follows: The kindergarten teacher formerly employed by the hospital, Miss Ruth Sencabaugh, had been in the public schools and became much interested in the problem. She was taken over by the Board of Education and made the principal of the hospital school. Through her, proper cases are selected and placed in various classes. She is recognized as the head of all educational work in the hospital, both by the board of education and the hospital. The teachers are responsible directly to her. She supervises and is in charge of the kindergarten work for small children. This is supported by the hospital to the same extent as heretofore.

EXTENDING THE INFLUENCE OF A HOSPITAL

Teaching of Diagnosis Made Available to Doctors at the End of the Earth—The Case Records of the Massachusetts General Hospital a Pioneer in This Field—Unique Character of the Course

By F. M. PAINTER, ASSISTANT EDITOR, CASE RECORDS OF THE MASSACHUSETTS GENERAL HOSPITAL, BOSTON

"NEVER have I, in the medical literature that I know," writes a professor of medicine, "seen anything more original, suggestive, and practical than this teaching."

"The original method you have developed in your work," writes another, "has been a great assistance to me in the course of my teaching."

The unpretentious series of case histories so surprisingly commended has proved its practical value even more strikingly to practicing physicians.

"These sheets," writes one, "are the most valuable and informing that come to my desk, and I look forward to their arrival with intense pleasure and interest."

"The best thing in any one line of medical literature I have ever received."

"I find them indispensable."

"I feel they are of inestimable value to me. Just what I have been wanting for years."

"No active physician can get more assistance from any source."

"I carefully study these at the expense of neglect of my medical journals."

"The most valuable addition to medical literature and teaching within my knowledge. They stimulate one to read . . . as nothing else can do."

"Oh, that we had had these *Case Records* thirty years ago! As for me, I should have been a better doctor."

"Charge us more, only for God's sake don't stop them."

The printed sheets in question are merely an extension of a method of teaching diagnosis, tested and perfected by ten years of trial before their existence. In 1905 Dr. Richard Cabot began discussing clinical histories before weekly classes of fourth-year students, house officers, and practicing physicians, Dr. Oscar Richardson reading and commenting on the necropsies, which he himself performed. Later the surgical cases were discussed by a surgeon, at first by Dr. Robert B. Greenough, since 1909 by Dr. Hugh Cabot. By degrees the system worked out into its present form. Abstracts of the clinical records of three or four cases that have come to necropsy are multigraphed and distributed to the class. The physician discusses the clinical history and the differential diagnosis, and makes his own diagnosis. The surgeon must in addition record his preoperative diagnosis before the report of the operation is handed to him. When the clinical evidence is all in, the discussion as complete as it can be from that evidence, and the clinician's diagnosis on record, the pathological findings are

discussed by Dr. Richardson, and the clinical and pathological evidence compared.

Obviously two great principles are embodied in the method, the mental stimulus of suspended interest, and the test of theory by fact. In the hands of masters of diagnosis the exercise becomes as absorbing as a game. It is skill and scholarship pitted against the unknown. For the moment the dingy pathological amphitheater becomes a jousting field. At the end of the discussion there is a moment of tense suspense while the pathologist, not without a sense of the dramatic value of the situation, comes forward to herald the outcome of the encounter. Defeated or in laurels, the clinician goes his way—in either case a better diagnostician by virtue of as rigorous a bit of mental athletics as a man can well undertake.

This tournament aspect of win-or-lose is, of course, the most superficial part of the interest of the exercises. To make a correct diagnosis is a small part of the value of the study of a case. Some of the most stimulating discussions deal with conditions so obscure or data so insufficient that positive diagnosis is impossible. It is in the weighing of the evidence given, the balancing of possibilities and probabilities, that diagnostic skill is needed. To the men who attend these classes their value lies in working under the leadership of an eminent diagnostician on a problem, even though it is insoluble, and then comparing, weighing, and tracing relationships between clinical and post-mortem findings. The exercise is often most helpful when it means being "baffled to fight better." From the tilt, any man may not only add to his knowledge but gain something of Dr. Cabot's courageous philosophy.

"If I make the diagnosis," he tells his classes, "I win. If I am wrong, I learn something. Either way I win."

It is not without interest that this austere method of discipline by fact should have originated with, and for twelve years been practiced by, a man who might well say to his critics, as Emerson said to Carlyle, "You sometimes charge me with I know not what sky-blue, sky-void idealism."

This is the method of teaching diagnosis which since April, 1915, the published *Case Records of the Massachusetts General Hospital* have been carrying to thousands of doctors. It is a pioneer method which has beaten out its trail in an honest and courageous search. The printed sheets make it possible for the man in Peru, Japan, or the Philippines to give himself something of the same training and to taste something of the same zest of problem-solving that he would have in the

class in Boston. A group of men in a Manitoba county society or on the staff of an isolated state hospital can find a much more vital and stimulating contact of minds and far greater practical benefit in working out such a case together than in listening to set papers. The arrangement of the *Records* makes it possible to follow the method exactly as is done in the hospital amphitheater. The clinical history is printed on a separate sheet, so that it can be studied quite by itself. The discussion, diagnoses, and necropsy findings are printed not only separately, but, at the suggestion of a subscriber, on paper of a different color.

"Your Seidlitz powder clinics," a reader calls them, "i. e., a blue one and a white one, to be mixed and taken while effervescing. . . . Allow me to say that these *Records* are an aid past all description to the isolated man, and I regret past telling that I have only of late subscribed. The beauty of the *Records* lies in their honesty. Long may they wave!"

It will, I think, be clear why subscribers write with so striking a ring of personal feeling. These are not merely readers. They are members of a class.

"To a great many of us," writes one, "these cases are the only post-graduate work we have at the present time."

"It awakens the interest of the reader," writes a South American, "associates him, so to speak, with the case under discussion."

There is no question but this sense of being present in a class or at a consultation is greatly enhanced by the excellent, almost verbatim reports which are now being published, giving the rapid-fire back-and-forth discussion of the doctors and the questionings of the students; a triumph of medical reporting, the most difficult branch of stenography known. This has been a comparatively recent outgrowth, like the half-tone reproductions of Mr. Brown's beautiful photographs and photomicrographs of specimens which have lately been added to the X-ray illustrations published since the second year. From the beginning, however, the effort has been to give the man at a distance a voice in the proceedings. Early in the history of the publication a circular was sent out asking for criticisms and suggestions as to ways in which the *Records* could be made more helpful, and the ideas in several hundred replies were carried out as far as was practicable. For three years every subscriber who let his subscription lapse was asked to give his reasons, in order that the *Records* might be improved. The addition of a certain number of cases with recovery, emphasizing therapeutics,

was made in response to many requests. The excellent system of numbering now in use, by which the number of each *Record* shows the date of its issue, was the ingenious idea of a subscriber.

From time to time questions have been democratically put to vote, and ballots sent out to be filled in. Shall more or fewer cases emphasizing treatment be included? Will a reduction in the number of cases issued weekly be satisfactory, as a matter of war-time economy?

The personnel of the voters replying has represented every rank of the profession, from the village doctor and the recent graduate to the professor in a leading medical school and the internist of national reputation. It has been in such replies to requests for criticisms or preferences, or in letters accompanying checks, that the many expressions of approval have been sent, a few of which I have quoted. If the large body of subscribers scattered over half the world shows something of the spirit of an enthusiastic and friendly graduate class, it is not a mere chance, but the result of a definite policy.

The distribution of this class is interesting. There is not a state or territory in the Union but is represented on the subscription list. Yet, though the most sparsely settled western states all have a showing—Montana, for example, with only a few more inhabitants than Buffalo, has fourteen subscribers, and Arizona, with not many more than Providence, has six—still it is the most progressive states which subscribe most largely. Not without honor in its own country, the series finds its longest state subscription list in Massachusetts. The next in order are those of Pennsylvania, New York, Illinois, and California. Taking the country in sections, the largest number of subscriptions are in the states north of the Potomac and east of the Ohio, the next largest in the Middle West, which has almost as many as the western and the southwestern sections together. Besides these, there are a considerable number of Canadians, a small representation of Mexicans, South Americans, West Indians, and Phillipine Islanders, and one reader in Japan. Among these widely scattered subscribers are fifty-seven hospitals, including one naval hospital ship; eleven medical libraries, including the Surgeon General's and those of Boston and New York; five insurance companies, four city health departments, and several great employers. Perhaps the most significant item on the whole list, however, is the subscription of the Surgeon General of the Army, which has several times been added to, and was recently increased from 216 copies to 481.

The inherent value of the teaching method has

been shown by its adoption and successful pursuit elsewhere. A class conducted along the same lines as Dr. Cabot's by the visiting physicians of the West Medical Service, Dr. William H. Smith and Dr. Roger I. Lee, with Dr. Richardson, has flourished since 1905, and has grown even under the adverse conditions of war times. Dr. Jane-way put the idea into effect in clinics at Johns Hopkins, and until a short time before his death carried on a regular exchange of papers with Dr. Cabot. When the latter followed his brother into war service in France in July, 1917, leaving the discussion of cases for the published series to Dr. Smith and Dr. Edward L. Young, Jr., both the substitutes modestly said, "It is the personality of the Cabots that has given this thing its vitality."

Yet in spite of the shock of war conditions the series is showing each month a growing subscription list, although it has had almost no advertising, as that is understood by the great publishers. It has two great elements of strength. It is a wholly honest submitting to the teaching of fact; and it has the gift of the gods of being interesting.

Incidentally the *Records* show a pleasant picture of professional team work. It is an admirable sight, and too rare, when a physician, a surgeon, and a pathologist, representing among them not a little fiery and imperious temperament, meet weekly for twelve years and harmoniously compare their widely differing points of view. If the series did no more than exhibit to the world the spectacle of these various specialists peacefully "grazing as one," it would not have existed in vain.

To carry not so much certain teaching as the class and the hospital itself to the isolated or the busy man; to take to him in applied form the newest and best in diagnostic and therapeutic method, with concrete example of its working; to help the varying needs of the practitioner in his practice and the teacher in his teaching; to jog the elbow each week, while books and quarterlies tend to become shelved or buried; and to do these things at a price so low that many subscribers have written they would rather double it than receive fewer cases; this is the unique function of Dr. Cabot's series. Other "clinics" bearing long lists of notable names and pushed by all the machinery of commercial enterprise have followed the pioneer. Yet the *Records* combine advantages which give them a place not filled by anything else in medical literature.

For everything we do or leave undone we must sooner or later pay the bill, and we should take this into account before we give our orders to fate.—Ellen Thorneycroft Fowler.

THE COUNTY JAILS OF ILLINOIS

The Disgrace of the State—Factors in the Promotion of Crime and Degeneracy, and Failures in the Protection of Society—New Laws Eliminating Worst Features of Old System

BY ANNIE HINRICHSSEN, EXECUTIVE SECRETARY, ILLINOIS STATE WELFARE COMMISSION, SPRINGFIELD, ILL.

THE county jails of Illinois are admitted to be the disgrace of the state. They were established for the reformation of offenders, the protection of society, and as deterrents from crime. They have not fulfilled any of the purposes for which they were created. On the contrary, they have proved powerful factors in the promotion of crime and degeneracy.

Not one voice is raised in the defense of the county jail. There can not be found in Illinois any official who will declare that the county jail as it is today is of the slightest benefit to a community.

And yet, so securely are they bulwarked by ancient prejudice that they stand impregnable before the attacks of practical reform and social

justice. They are the definite expression of the public attitude toward the alleged law-breaker. They state in terms of stone and steel, darkness and hunger, that, for the man accused of crime, Illinois knows no justice. They state in terms of dollars and cents that the tax-payers support, at heavy expense, a factory whose only output is crime and disease.

The first official survey of the Illinois jails was made in 1870 by the newly created State Board of Charities. The report of this survey is a tale of horrors. The jails are denounced as filthy dungeons unfit for human habitation. The methods of care of the prisoners are pronounced inhuman and ineffective.

This survey resulted in a new jail law. This law, practically unchanged, is the one under which the jails are, nominally, operated. It requires the sheriff to furnish the prisoners with abundant food, plenty of water for drinking and bathing, to keep the jail clean and sanitary, to provide certain toilet facilities, and to separate the different classes of prisoners.

Nearly every year since 1870, the state has inspected the jails. The last report, published in 1916, differs little from the report published in 1870. Many of the same jails are in use, and the method of operating them has not changed. Five-sixths of the jails are today just what they were fifty years ago—black dungeons into which



Fig. 1. The cell block of the old Peoria jail.

air and sunlight can not penetrate, filthy with vermin, disease, and the accumulated odors of the fetid air of many years.

The jail law is ignored in nearly every county. When, as inspector of institutions for the State Charities Commission, I visited every county jail in the state in the year 1915, I found that only a small minority of the sheriffs had read the state jail law. Many of them had never heard of it and did not know there was one on the statutes. Those who had read it and conscientiously wished to observe it were unable to do so on account of the construction of the jails. The most important section of the law, the one requiring separation of different classes of prisoners, could not be enforced in a building which had been erected for a dozen prisoners and in which fifty must now be held.

A new jail is the last institution which even the most enlightened community is willing to erect. Public sentiment does not regard the jail problem as among those requiring social discrimination.

The majority of the jails are more than fifty years old. Several were built seventy-five or eighty years ago, and two, the boast of their counties, were in use before Illinois became a state.

There are three kinds of architecture in our Illinois jails: the basement jail, the stone-block jail, and the iron-cage jail.

The basement jails are several feet under ground. Air and light can not enter; rats, vermin, and sewage seepage do. The walls and floors are wet, frequently with sewage seepage.

The stone-block jail is a block of stone or brick built in the center of a large room. In its sides are small, dark caves, so small and dark that they appear as black shadows against the block's surface. These caves are the cells in which the men live.

The iron-cage jail is a barred room built in a larger room. The iron cage contains cells of bars or solid iron. These are the so-called more modern jails, and some of them are light and well

ventilated. When the cage is built in line with the windows of the room and the windows are opposite the barred open spaces, there may be light and air.

The furnishings of the jail depend upon the generosity of the county board and the insistence of the sheriff. The beds are usually steel wall cots and canvas hammocks with blankets for coverings. A few of the jails have good mattresses, sheets, and pillowcases.

The toilet facilities may be shower baths and

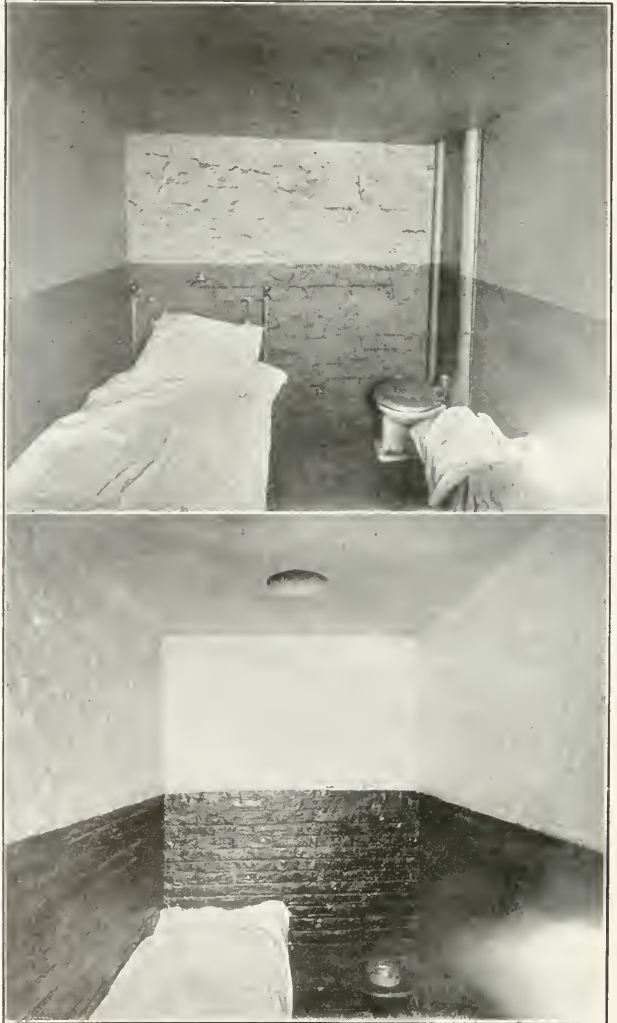


Fig. 2. Women's cells. No light, air or sunshine can enter. Will these cells reform erring women?

modern plumbing; they may be a few tin cans and a metal laundry tub, in which twenty men wash their bodies and their clothes.

In the southern counties we find fewer toilet facilities. Here we find the metal laundry tub with all its horrors. This tub is the only bathing convenience provided. In it men wash their bodies and their clothes. Sick men and healthy men bathe in it; sometimes twenty men must use this one tub. The water, heated on the jail stove, must be carried to it; for there are no water and sewage pipes in the jail. The common towel may be in use, or one may be shared by three, four,

or more men. The towels are washed, if washed at all, by the prisoners themselves. They do not receive the germicidal benefits of sunshine and steam.

The buckets are sometimes substantial ones with tightly fitting covers; sometimes they are battered tin pails which have seen service elsewhere; again, they are tin vegetable cans.

The methods of sewage disposal can be recognized half a block away. In central and northern Illinois we find slightly improved toilet and sanitary facilities, and, when least expected, a jail which is unfit for a human being to enter.

The prisoners are held in complete idleness. The law provides for work, but no systematic effort has ever been made to put the law into effect. A small number of the men work around the jail; their efforts, however, are hardly more than perfunctory. Occasionally a sheriff has set his men to painting and yard and street cleaning. Again we find public sentiment against a better jail system. In several counties strong pressure has been brought to bear to prevent the labor of the prisoners, the claim being made that work is being taken from worthy persons to benefit law-breakers. In spite of the scarcity of labor and the abundance of work, this claim is being considered and few county officials have disregarded it.

In six county jails men and women occupy adjoining cells in the same room.

There are seven detention homes in the state, and, in ninety-five counties in which there are no detention homes for juvenile offenders, the children are held in the same jail with the adult prisoners. In two-thirds of the counties the boys are kept in the same rooms, frequently in the same cells, with the older offenders. Girls of fifteen and sixteen, arrested for the first time, are found in rooms with the most depraved women of the streets.

Physical examinations upon entrance are made in only three jails, and in the others, the prisoners are herded together regardless of disease.

The county boards allow the sheriffs "per-diem" fees for the food of their prisoners in the county jails in all counties in Illinois except Cook, St. Clair, and Rock Island. These fees vary from thirty cents a day in Sangamon and Macon counties to \$1.25 a day in Brown county. Fifty cents is the average.

The great evils of this system are the under-feeding of the prisoners, the number of unnecessary arrests and the development of the bitter antisocial spirit in the prisoner. The sheriff naturally expects to make a profit on the food of the prisoners. From the earliest days of jails and

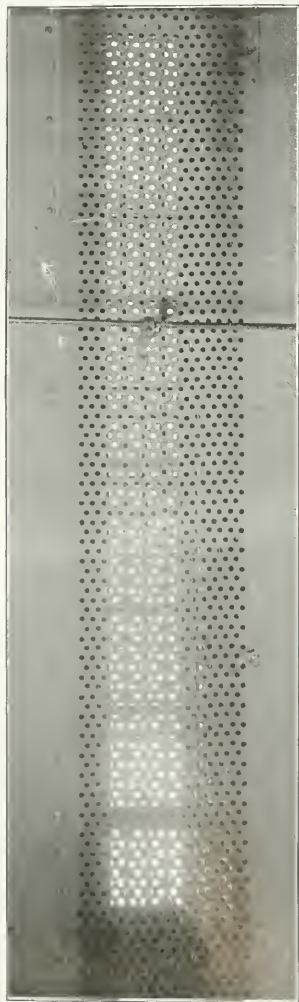


Fig. 3. Perforated sheet iron used at the windows instead of glass.

sheriffs, the sheriffs have expected to make a profit on their prisoners' diet. The extent of the profit may depend upon the sheriff's kindness of heart more than upon his sense of honesty.

The larger the number of prisoners, the greater will be the profits, and, consequently, the jails must be well filled. This circumstance has for so long been recognized as a matter of course that the sheriff who keeps his jail well filled is not regarded as a vigilant officer of the law as much as he is regarded as a thrifty business man.

The greatest evil of this vicious fee system is the effect on the prisoner. The prisoner knows what the sheriff receives for his food; he knows that the sheriff receives fifty cents a day and gives him ten cents worth of food; he knows that the sheriff is using his degradation as a means of filling his own pockets; he knows that the sheriff, as an officer of the law, is using his prisoners' degradation and his own office as a means of law violation for personal gain, and is protected in his law violations by the very law that he is sworn to enforce. This knowledge develops in the prisoner a hatred and a contempt for a law administered with the grossest injustice, and this hatred and contempt of the law find expression in greater crime.

If any one doubts this statement, or would modify it, let him go into the jails of Illinois and talk to the prisoners, to the repeaters, to the men who are serving, or have served, penitentiary sentences after one or more terms in the county jails.

This antisocial attitude among prisoners and ex-prisoners is a definite condition. Its terrible strength is shown in the histories of the men who repeatedly violate the laws, who come again and again into the courts. We do not assert that it is one of the chief contributing causes of crime, but we do claim that it is one cause, and one for which we can place definite responsibility.

The jail is not a strong-box for holding desperate criminals. Desperate criminals constitute only a very small percentage of the jail population. The jail inmates are petty offenders and persons too

poor to pay fines or provide bail. Jail sentences are imposed for misdemeanors and failure or inability to pay fines. Murder and treason are the only unbailable offenses. Consequently, nearly every person charged with crime may, if he has money or friends, have his freedom until conviction.

The prisoner may remain in jail for as long a period as two years. Cases may be continued through many terms of court, and prisoners may remain in jail for a year before trial and for as long as a year thereafter to serve sentence.

The statement was made in a preceding paragraph that the jails of Illinois are a powerful factor in the promotion of crime and degeneracy.

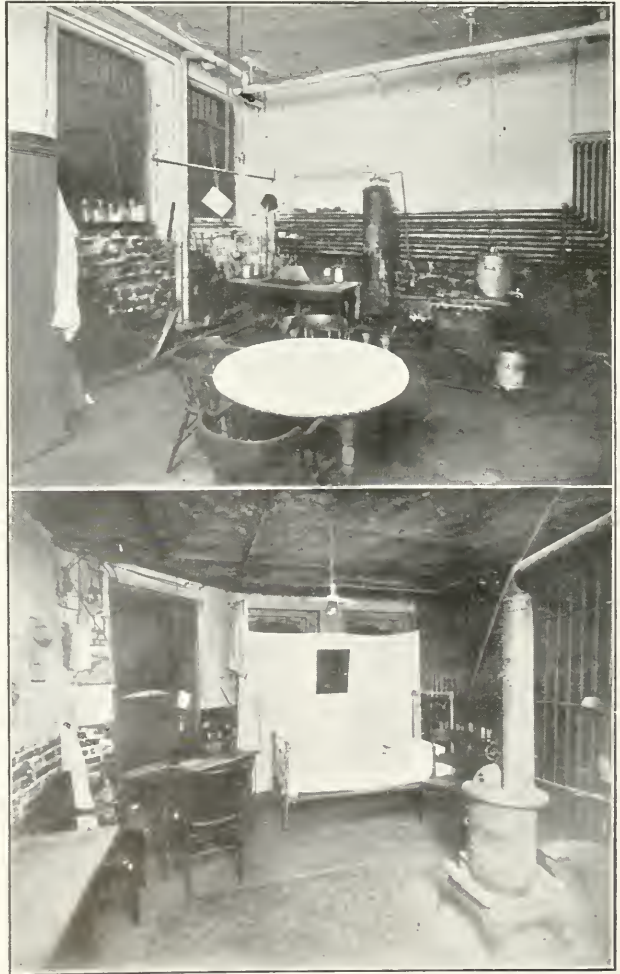


Fig. 4. Kitchen and matron's office in a Chicago jail.

I have attempted to develop this statement in detail. In summing up the developing paragraphs, I present the following reasons for my statement (1) their physical construction; (2) their method of operation; (3) their enforced idleness of prisoners; (4) the fee system of feeding.

1. The physical construction of the jails is such that they are insanitary, ill-ventilated, dark, and too small or too poorly planned to permit of

by the determination of the sheriff to eliminate as many evils as possible.

3. The enforced idleness predisposes the prisoner to every kind of moral, mental and physical contagion.

4. The fee system of feeding, long recognized as a legitimate source of profit for the sheriff, proves to be a means of rousing in the prisoner a contempt for the law; it sends him forth from the jail a greater enemy to society than he was when he entered it, and more fully prepared for a career of crime.

Physically, mentally and morally, the men go forth worse than they were when they entered, and they go forth hating the travesties called laws which have been repeatedly violated by the officials in their efforts to punish them.

For many years the State Board of Charities and its successor, the State Charities Commission, demanded better jails and a system which would eliminate the jail except as a place of temporary detention of persons waiting trial.

A demand for a new jail brings as effective results as are brought by beating with bare hands against a granite wall. A demand for a new jail system has been satisfactorily answered by the last General Assembly.

The State Charities Commission

asked for two laws which will materially decrease the jail population and eliminate several of the worst features of the jail problem.

We asked for a state work farm and the abolition of the fee system of feeding prisoners. The bills were passed.

Several of the states have established work farms for petty offenders and these farms have proved a means of solving a part of the jail problem. The men work in the open air, the classes of offenders are separated, and the "per-diem" fee system of feeding is not used.

With little opposition a bill was passed authorizing the Department of Public Welfare to establish a work farm for offenders over the age of sixteen years who would serve sentences of sixty days or over in the county jails. The plans for the work farm are now being made by the department.

The bill abolishing the fees to sheriffs for the food of the prisoners proved a difficult one. It required the sheriffs to buy the food, to hire it prepared, and to present itemized bills to the

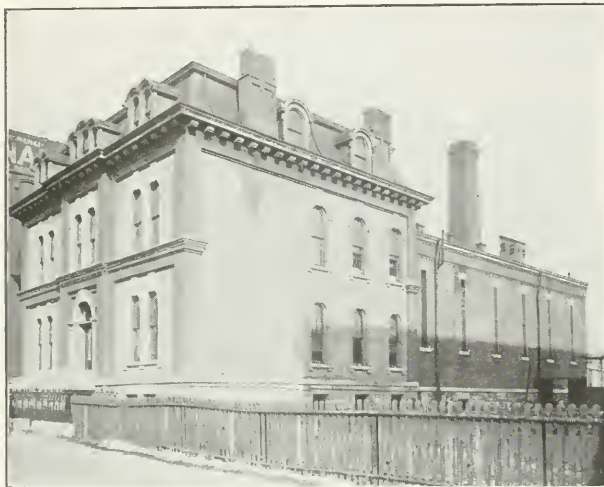


Fig. 5. This pretentious building is the sheriff's residence. The annex at the rear is the jail, a typical form of jail architecture.

the classification of prisoners, or of the separation of the healthy from the sick. The health of the men must suffer; communicable diseases are certain to be passed around among them. The lack of fresh air, exercise and stimulating interests makes the prisoners particularly susceptible to disease, both physical and mental. The herding together of all classes, regardless of age and degree of crime, spreads a moral contagion through the jail; and, as with the physical contagion, there are no counteracting influences.

2. The method of operation may make even a modern jail vilely insanitary. Clogged air shafts, disabled plumbing, filthy bedding, the common towel and drinking cup, the tub in which all must bathe, the lack of steam and sunshine for towels and bedding, the closed and grimy windows, the presence of rats and vermin, failure on the part of the sheriff to enforce the classification law—these conditions can make, and in certain instances have made, even the better jails as dangerous as the worst. On the other hand, several very poorly constructed jails are made habitable

county board. The law was not to go into effect until December, 1918, when the new sheriffs take office.

It was predicted that this bill could never be passed, and a powerful lobby was organized to defeat it. It was denounced as anarchistic, ultra-radical, maudlin, and a deliberate rebuke of the present sheriffs. On the other hand, many of the most influential members of the house and senate

the dungeons many of their worst evils. They will not be overcrowded. The prisoners will not be herded together regardless of age, nature of crime, or physical condition; men will not serve sentences in idleness surrounded by the most vicious influences; they will not be fed, or underfed, for official profit.

Public sentiment, as expressed by the General Assembly, is in favor of an enlightened system.

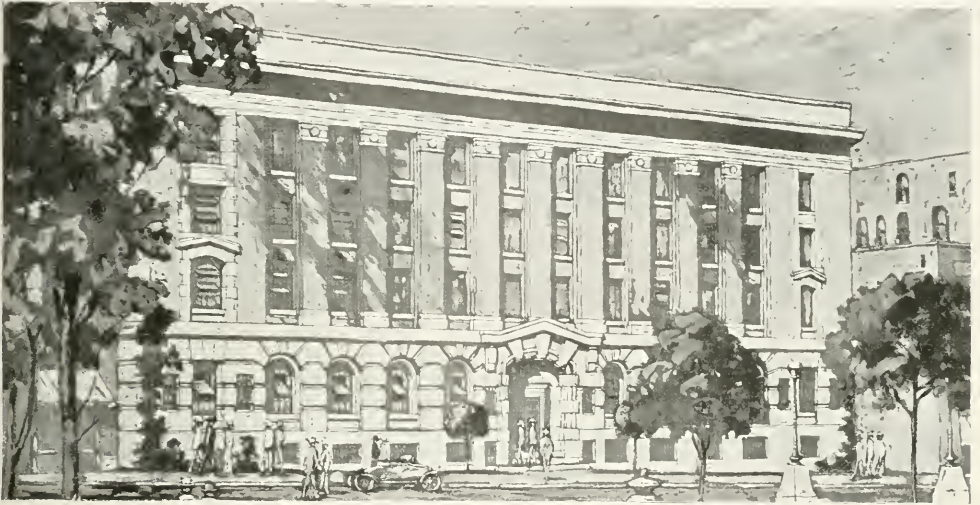


Fig. 6. Peoria County jail, recently erected, the most sanitary and best-constructed jail in Illinois.

strongly favored it, and several sheriffs urged its passage.

It passed the house by barely enough votes to carry it to the senate. When it was first voted on in the senate it was defeated; the following day, however, it was called up for reconsideration, and, after one of the liveliest debates of the session, it received enough votes for its passage. It was among the first of the bills signed by Governor Lowden.

The removal of the sentenced prisoners will decrease the jail population and make possible better sanitary facilities. It will also enable the sheriff to separate the different classes of prisoners.

The change in the method of feeding prisoners will further decrease the jail population by decreasing the number of arrests. There will be no incentive to the sheriff to underfeed his men; and the prisoners will not be exploited for financial gain.

The ancient dungeons of Illinois will not be erased from our map for many years. But the old system has yielded to fifty years' bombardment, and the change of systems will take from

And it is not too much to hope that this sentiment may eventually include the time-dishonored bastilles and drive these relics of barbarism from the state.

Progressive Social Service Legislation in Saskatchewan

Progressive legislation has been one of the things for which western Canada has been famous these many years, but nothing so radical has yet been passed as the recently proposed law, making it a punishable offense for anyone suffering from social diseases to marry. That such a law will undoubtedly be passed at the next session of the legislature is predicted in a statement issued by the Saskatchewan Social Service Council, which has been exceedingly active in work of this kind, and which has received assurances from the government that something of this nature will be taken up. A year ago the Saskatchewan government took action in advance of the recent decision of the United States Government establishing anti-vice zones around army and war work centers, and passed a law making failure to report to the provincial health authorities all cases of this kind, an offense punishable with severe penalties.

It is expected that under the law which is now contemplated a government certificate of mental and physical fitness will be required before marriage may take place, and those who are acquainted with the processes of the law in Canada declare that such a statute will be rigidly enforced.

INSTITUTIONS FOR THE CARE OF EPILEPTICS*

Selecting the Proper Location—Why Patients Should Have Employment—As to the Proper Size of a Colony—How to Construct Cottages—Arrangement for Employees—Studying Individual Needs of Patients—How to Provide Instruction and Proper Medical Care

BY WILLIAM T. SHANAHAN, M.D., MEDICAL SUPERINTENDENT, CRAIG COLONY FOR EPILEPTICS, SONYEA, N. Y.

THIS subject is one which, during recent years, has received much attention. When selecting a site for a colony or village for epileptics, careful consideration must first be given the following: an abundant, accessible, sanitary supply of water, not too hard; the safe disposal of sewage; soil of such quality that the larger part of the site can be tilled as the colony develops; a topography providing natural means for separating the sexes and also the mental grades, and permitting the carrying out of landscape gardening with proper layout of roads, walks, trees, shrubs, etc.; adequate rail facilities for receiving supplies and for ingress and egress of residents of the colony and of visitors; and in addition, proper highway facilities about premises and to near-by villages and cities. The institution should be reasonably near a city or large village, so as to provide means for employees to secure recreation when off duty. The site should contain tracts available for the erection of buildings without necessitating a great amount of preliminary grading. Whenever possible, the heating and lighting plant should be centrally located, so as to avoid the additional cost of maintenance and extra labor entailed in consequence of multiple plants.

The first patients to be admitted should be those epileptics physically capable, barring an occasional seizure, of working regularly and requiring the least supervision. If at the outset patients are admitted irrespective of their physical or mental disability or of both, it will be difficult with such a handicap to develop the institution properly during the early days of its existence when every bit of energy that can be secured should be utilized for constructive purposes.

Only after the essentials have been well started and proper accommodations provided for workers and necessary help, should the admission of the more marked mentally and physically disabled epileptics be given favorable consideration. The

colony will grow toward completion more satisfactorily if this one idea is borne in mind. One of the greatest problems institutions have to contend with is the providing of proper care and supervision for those of its inmates who are markedly defective mentally.

A conservative estimate is that at least one in five hundred of the general population is epileptic. Of this number about 25 percent may apply for admission to a state colony.

Of the epileptics ordinarily seen in our institutions, the majority exhibit some mental abnormality, the degree of which varies in different individuals and also from time to time in the particular individual. Some, during the interparoxysmal period, show practically no evidence of their affliction. Many, however, have recurring periods of mental disturbance, lasting in some for hours, in others for days or weeks, after which they clear up. Not infrequently a progressive mental deterioration goes hand in hand with such recurring periods. Epilepsy and primary feeble-mindedness, when associated, are but concomitant signs of a defective make-up. Because of these various phases of mental instability and the associated convulsions, an institution for the care of a considerable number of epileptics should, when possible, be so planned that proper provision can be made for all types, irrespective of their mental condition. When sufficient land is available, at least one acre per patient, there should be no difficulty in so grouping the buildings as to provide sufficient separation of the different mental grades.

As to the ultimate size of a colony, there has been much discussion along both theoretical and practical lines. Ordinarily the institution having capacity for five hundred patients can have a reasonable variety of occupational and recreational activities for therapeutics, can maintain various industries of a value toward lessening net cost of maintenance, and can provide facilities for satisfactory classification and scientific care and treatment, under the guidance of an executive who can have a close personal and intimate familiarity with the operation of the colony and an acquaintance with its inmates. In an institu-

*This paper is the fifth in a series, by various authors, on the classes of special hospitals. The first, "Standards for a Children's Hospital," by Stafford McLean, appeared in May; the second, "The Standards of Hospital Education for Interns," by J. M. Baldy, in June; the third, "The Standardization of Hospitals for the Insane," by William C. Sandy, in July; the fourth, "Standardization of State Hospitals," by A. L. Bowen, in August.

tion with two or three times this population, the superintendent must perforce have a less direct relation to the various phases of institutional activities. As to economical administration, there is probably nothing gained after an institution passes a capacity of perhaps a thousand inmates.

The average epileptic in a colony can be allowed entire liberty about the premises and various privileges consistent with the mental status of the individual. Serious quarrels or infractions of rules are not more frequent than in an ordinary village for the same population.

The plea is often made that the presence of the insane and the lower-grade epileptics has a depressing effect on the other patients and deters many from entering the special institution. If the structures for the more deficient type are placed at some distance from those for the brighter class, and partly or completely hidden from view by trees or elevations of land, there can be no serious objection to having all types in one institution.

The epileptic, being subject to a mental or physical incapacity which may be either partial or complete, transitory or permanent, very often is in consequence barred from remunerative employment in the outside world, thus becoming a dependent on his family or the community. In the home he is a constant source of sorrow and anxiety, and in institutions planned to care for other types of defectives he is a disturbing element because of his recurring seizures.

The village idea, with varied but harmonious types of architecture, should be ever foremost in the development of a colony so that the stamp of the institution may be as much in the background as possible. Preceding the inauguration of the colony development, quite complete plans as to its ultimate size, arrangement of groups, etc., should be carefully formulated, but these plans should not be so fixed that the benefits of experience cannot be applied as the colony passes through its different stages of growth.

Difficulties encountered by hospitals in obtaining funds for development are common, but oftentimes there are special troubles besetting state institutions, owing to lack of full first-hand information by the appropriating bodies of actual requirements and the purposes of the particular institution. Plans for progressive development may be delayed for many, many years because of lack of adequate funds.

Proper classification of patients is of the utmost importance, not only for care and treatment, but also for scientific research. The smaller the cottages and the nearer they approach a home,

the greater the success in classifying and the more nearly the structure affords contentment for its residents. The furnishings should be simple but ample.

The best type of building for a colony for epileptics is the one or two-story cottage, simple but attractive in design, those for the brighter patients accommodating not more than from fifteen to thirty-five and the cottages for lower mental grades somewhat larger; but under no circumstances should a single structure be erected to accommodate more than seventy-five. The per capita cost of maintenance in the small cottage with its close approach to home life is practically the same as in the large structure where this important phase is lacking. Where stairways are necessary, they should have a gradual ascent, having broad treads, low risers, high railings and round corners. The flights should be broken by frequent landings. The fewer the stairways the smaller the number of injuries, the easier it is to get the patients out of the building, and the greater the ease of supervision. Ramps may be used to advantage in place of stairs. For ease of supervision, egress of inmates and simplicity, the one-story structure for the more helpless types is to be preferred.

The cottages may be erected of frame, concrete, brick, or stone, insuring a little variety to the structural plan of the community. Cottages should not be too ornate and of exceedingly costly construction, nor, on the other hand, should false economic methods demand that they be so cheaply built that constant repairs will be required to keep them in habitable condition. The cost per capita will necessarily vary somewhat with the site of the colony, but in no instance should common-sense methods be lost to view.

Separate groups, each with its central kitchen and dining-room or separate dining-rooms for the smaller cottages, should be arranged for proper classification, somewhat after the following plan:

1. The administrative group, centrally located and providing for executive building; accommodations for physicians and other officers, cottages being provided for those who are married; hospital properly equipped to care for acute surgical and medical cases; reception cottage; assembly hall; school; field for outdoor sports; laboratory for research work and a chapel. Opportunity for attendance at chapel services on Sunday makes for contentment and is a feature of the village plan.

2. A group of industrial buildings, including laundry, and various shops, should also be located so as to be readily accessible. The central store

house for food, clothing, household supplies, etc., should have alongside it a railroad switch as should also the central heating and power plant. There should be facilities for unloading and storing coal sufficient for use over an extended period.

3. The colony should be divided into two principal parts for the sexes and then each of these two groups subdivided as follows: (a) group for the better mental grade of colonists; (b) group for middle grade, many of whom are good workers; (c) group for insane epileptics, provision being made for both the acute recurring cases and the chronic cases; (d) isolation cottages for the tuberculous and for those having contagious diseases; (e) infirmary group, with adequate sick wards, for the low-grade idle patients; (f) for males, one or more farm colonies.

In the cottages for the acutely ill, which naturally includes those in a disturbed mental state, and in the small cottages for the brighter class, there should be a few rooms for but one patient each, but, as a rule, small wards are to be preferred to single rooms. In the ward, better supervision is possible both by attendants and by fellow epileptics, whose assistance should always be available.

There should be ample day or living-room space in all cottages, an abundance of windows furnishing ventilation and light, and adequate bathing facilities, showers being preferred to tubs. The smallest possible amount of construction to afford opportunity for injuries during seizures is an essential which must not be overlooked. All corners and projections should be rounded. Toilet rooms should have the water closets exposed so as to permit proper supervision, slate partitions and doors on individual sections being entirely out of place. All plumbing should be simple in style and readily accessible for replacing. Buildings easy of ingress and egress are ideal for any class of defectives but especially for the epileptic, subject as he is to disturbances of consciousness. All radiators, cookstoves, machinery, etc., must be carefully provided with proper guards. All steam and hot-water risers and radiators must be covered or the latter must be placed high on the wall. Indirect heating is desirable if funds are available to permit of installation.

The number of employees to be placed in the immediate care of the patients depends on the type of patients. A ratio of one attendant to fifteen patients is sufficient for the workers. For those physically or mentally impaired, or both, twice the number of nurses and attendants should be provided. Employees, especially the nursing force, must be given comfortable quarters when

off duty. Their labors are such that this is mandatory. They should be liberally treated as to hours of duty, recreation, annual vacation with pay, medical attention if ill, etc.

The arrangement for housing help necessary to be kept on premises is an entirely different problem from that which confronts the average institution in a city. In the colony with ample acreage, individual cottages, or bungalows for married heads of departments and certain other employees must be had, as practically all such employees must be kept on premises of an isolated colony, so they may have normal family life. In an isolated community, such as an institution of the type under consideration, there must be maintained a police and fire organization. Even in fireproof structures a liberal installation of fire risers with sufficient hose to cover all floor space and plenty of hand extinguishers, with the use of which all employees should be familiar, are the best means of protection against fire. Facilities of this nature enable prompt combatting of fire in its earliest stages. Hose carts, hook and ladder trucks, chemical engine and other pieces of portable apparatus are of value, but, owing to time which must elapse before they can be put in operation, they cannot compare with the fixed hose reels and hand extinguishers for prompt action. Regular drills must be had in the use of such protective apparatus, as well as drills for patients in rapidly leaving buildings in an orderly manner. It goes almost without saying that telephonic communication should be ample, its lines and those for carrying electric power for lighting and power being in conduits in and out of doors, when funds permit.

The patients should be divided into the voluntary and the legally or judicially committed. Many of those sent to a colony should be kept there indefinitely, both for their own good and for that of the public. The colony authorities should also have power to secure the judicial commitment of those whose mental condition deteriorating precludes their residing outside of an institution.

Epileptics who are primarily defective to a marked degree or who are much demented will not ordinarily improve materially as a result of colony treatment. The average epileptic does, however, after a residence of several months, show more or less improvement, in regard both to his epilepsy and to his general health as well, some having a complete cessation of seizures.

The occupations offered the colonists should be most varied. There is no good reason why the epileptic whose mentality is not too low should

not, under proper direction, pursue any ordinary avocation barring one which would place him in situations dangerous to him because of his seizures. Work is especially valuable as a means of treatment, as carefully regulated occupation seems to lessen oftentimes the number of seizures and prevent mental deterioration. The type of employment should, if possible, prove interesting, and in many cases must be of a character different from that pursued previous to admission to the colony.

The most valuable form of labor, both from the standpoint of treatment and from that of monetary return to the colony, is perhaps out-of-door work in the garden and on the farm, with their diversified interests including forestry, breeding and raising of live stock. After that in importance comes the work in the shops, household, laundry, sewing rooms, etc. If sufficient suitable land and equipment are available, there is no good reason why all vegetables and milk required, and a considerable portion of the meat, eggs, fruit, etc., cannot be raised on the colony premises. A considerable proportion of repairs and minor improvements can be done, largely by patient labor, and many articles, such as mats, rugs, brushes, brooms, willow baskets, mattresses, clothing, stockings, caps, hats, etc., made by the colonists. The making of soap, printing and binding, caning chairs and other activities can easily be carried on. As the institution grows, the industrial work can be progressively developed. Local conditions may permit special industries, for instance, brick and tile-making, forestry, butter and cheese-making, etc.

The earning capacity of the epileptic, as a class, has been overestimated by many of the general public, and even by some more familiar with the special care of such unfortunates. The very word "defectives" should imply that one should not expect a community of defectives to be self-supporting. Of the total number of epileptics in the average state colony, about 50 per cent are capable of doing labor of some kind and from 10 percent to 15 percent can perform considerable work when not incapacitated in consequence of seizures.

Recreation and occupation are closely related to the general medical work. Conscientious heads of departments, sympathetic in nature, should be appointed so that it will always be evident that the diversions are therapeutic measures primarily and for entertainment secondarily and that industrial departments are for monetary return less than for therapeutic value.

School instruction, both manual and scholastic,

must be had for the younger colonists. A band and orchestra of patients should exist for the benefit of the patients who are members, and for use at dances, band concerts, etc., thus affording pleasure to the entire resident population. Various games and sports, both in-door and out-door, should be encouraged for self-evident reasons.

Systematized occupation, regular hours, selected diet, hygienic life (of prime importance in the treatment), can best be carried out in the properly designed and arranged special colony where every action, if need be, can be regulated to meet the indications of the individual. Habits of personal discipline and self-control are inculcated so that the patient of average mentality is enabled to cooperate better in the plan outlined for his treatment.

A state institution must perforce expect to provide the common necessities of life without the luxuries which a private, well endowed institution would be in a position to furnish its inmates. In judging a state institution's standards, this fact must be ever foremost in the mind of the examiner. Proper housing, food, clothing, medical and nursing care, sensible hygienic methods as to bathing, recreation, etc., withal reasonable opportunities for relatives and friends to visit patients and the assignment so far as means permit of compatible patients in each cottage, are demands which should be met. The proper care of inmates should not, however, be based solely on economy. The best care in the proper sense is most economical. Liberal rules regarding visitors make for contentment and show the public that the work of the institution is for all.

A reception cottage, properly arranged and equipped, to which is assigned a sufficient nursing force under the direction of an experienced member of the resident medical staff, is of prime value in the organization. This should be the portal of entry where, based upon scientific observation coupled with common sense, is made the classification upon which all subsequent care and treatment are continued. For clinical research and laboratory investigation, various initial examinations and tests can be applied to ascertain leads to future efforts. The resident physicians assigned to this work should be practical in their methods and inculcate similar views in the nursing force. Close application to the study of the recent arrival is necessary to bring about his proper readjustment to his new and oftentimes strange environment. He may never have previously seen another epileptic having a seizure, never have been under discipline, and prior to his coming to the colony, he may have been heavily dosed with seda-

tives, harshly treated perhaps for incidents resulting from his disorder and deprived of the broad perspective of what his condition is and what he himself must do and accept if an improvement is to be sought. Persistent effort in direct relation with the patient on the part of the physician and nurse must be had to enable the newcomer to successfully pass through this early and all-important phase of colony life. The colony or village with a well-working plan for this situation deserves a high rating.

The work done in a state institution should never be spectacular or sensational in character nor should the curriculum of its training school for nurses be too erudite to prove impractical. The physician must spend the greater part of his time in the cottage and ward with his patients if he is to have a proper perspective of the disorder he is studying and seeking to alleviate. A minimum of ordinary office desk labor and a maximum of clinical observation should be the points on which judgment is passed as to the medical work of a state colony.

POINTS ON WHICH TO BASE STANDARDIZATION

For self-evident reasons the standardization of special state institutions for epileptics is not as readily obtainable as is the standardization of general hospitals. For comparison, however, the following headings might be considered:

Medical Staff.—There should be such completeness and yet simplicity in organization that there will be cooperation between the resident and consultant staff, even though remote location may prevent as frequent visits by the latter as can be made in a general hospital; nevertheless, the general field of medical effort can be well covered.

Members of the visiting staff are, as a rule, consultants, as the actual routine medical work must be done by the resident staff, referring to the medical staff eye, ear, nose and throat cases and only special neurological, surgical and medical cases. Smallness in numbers of the resident staff or closeness to large urban centers would modify this plan.

The resident staff of the colony will vary in numbers with the size of the village, but in an institution sufficiently large to permit of such an organization, there should be first assistant and one or more senior assistant medical superintendents; several assistant physicians in charge of groups or divisions, reception service, infirmary service, etc., a woman physician, dentist.

The present military requirements, the reduced number of medical graduates and the disinclination toward institutional work, are among the

factors causing increasing difficulty in securing for institutions physicians who are energetic clinical research workers.

Team-work, including coordination with administrative departments, is essential in maintaining medical standards and the discipline as the whole. Space will not permit going into detail as to the scope of administrative duties each and every assistant physician should accomplish, but suffice it to say that each officer should interest himself in all phases of the care and treatment of the patients under his particular charge.

The number of resident physicians per patient should be at least 1 to 250 for group for middle and lower grades and 1 to from 50 to 75 for acute hospital and reception services. There should be among the resident staff a competent surgeon, internists, a roentgenologist, a woman physician, a dentist, a pathologist and bacteriologist and psychiatrists, so that all phases of medical effort can be efficiently advanced. The scheme of organization, for cooperation of scientific with domestic departments, should consist of dividing the colony in supervisory groups each under control of an assistant physician and nurse, all reporting regularly in writing and person to the medical superintendent.

The arrangement of space for x-ray work, exposures, skiagraphs, fluoroscopy, dark room, and library should be adequate in the way of equipment.

The character of the work in the diagnosis and treatment of disorders other than epilepsy should be of as high a standard as in a general hospital with a much more rapidly changing population. To accomplish this, post-graduate work in clinics located in our large medical centers should be mandatory for members of the resident staff.

As the medical and nursing staff, so the character of hospital work will necessarily be. The medical attention and activities are reflected along the line from the physician with the highest authority to the probationer acquiring the rudiments of nursing. Without an energetic and enthusiastic corps of physicians, working hand in hand, a proper hospital atmosphere cannot be created and sustained. Petty jealousies and fault-finding with lack of team-work do infinite harm, whereas out-and-out free constructive criticism is valuable. On the other hand, one who cannot bear just criticism is a detrimental factor and a drag in the institutional machinery.

Training School.—The training school for nurses should have a competent principal who can direct its work, and, aided by the assistant

physicians and head nurses, carry out successfully a curriculum essentially practical in nature. Probationers of good reputation, active, in good health and with a preliminary education of at least one year high school should be sought. The period of training should be three years, nine months or one year of which should be in an affiliated general hospital of high standing in a near-by city, so as to give a broader experience.

The discipline of the training school should be reasonable in nature, demanding both theoretical and practical efficiency. Classrooms with proper apparatus should be had for lecture and demonstration purposes. For those in training, as well as for graduates, there should be proper living accommodations in a separate cottage or cottages, with single rooms for all, club rooms, library, etc., with opportunities for post-graduate work of graduates of the school.

Laboratories.—The director of the laboratory should be a trained pathologist and bacteriologist with necessary assistants, both medical and lay. The comprehensiveness of the scheme of organization should permit the making of all routine clinical tests: blood, cerebrospinal fluid, urine, feces, sputum, throat cultures, Widal and blood pressure, etc., as well as the furthering of research work.

The scientific atmosphere of the colony under inspiration of laboratories should be very apparent. Neuropathological, general pathological, biochemical studies with careful records of findings and preservation of brains, various specimens, etc., should be actively pursued.

This work should be closely related to and in many respects should be done with the cooperation of the medical staff.

Physical equipment should be ample: incubators, refrigerators, microscopes, microtome, centrifuge, photographic and microphotographic outfits, animal house, etc. Architectural arrangement should ensure spacious histological and pathological work-rooms, with abundant light, both natural and artificial. There should be well-planned dark-room, gas, electricity, water, both hot and cold, mortuary, autopsy room with cold storage for bodies, library, space for storage of specimens, etc.

Original Work and Publications.—The subject of epilepsy and its phenomena, as well as related or allied disorders, should be presented by the pathologist as well as other members of the medical staff before medical societies and by publishing papers on the same in general and special medical periodicals. All original work should be predicated upon thoroughness of investigation

with familiarity with all earlier work along similar or related lines.

Pharmacy.—The drug-room, with all facilities for filling prescriptions, making of preparations, pills, percolating, etc., so far as such might prove necessary or desirable, with adequate storage room, should be at a central point from which prescriptions, etc., can readily be distributed to various outlying cottages. It should be under charge of a registered pharmacist with such assistants as are necessary. In the outlying cottages should be small drug cabinets for emergency use and in which to keep filled prescriptions. The pharmacy, while an important feature in a colony, is perhaps relatively less so than in a general hospital.

Out-Patient and Social Service.—Field work should be arranged to follow up discharged patients, investigate applicants, diffuse information generally about the aims of state institutions, and for such other purposes as might suggest themselves. The director of social service should have medical training, as should also, to some degree at least, the assistants.

Many epileptics could readily live outside an institution and arrested cases could be kept free from symptoms, if the general principles of right living could be planned and adapted for them by experienced field agents.

The frequent holding of clinics at the institution to which physicians within reasonable distances should be invited and encouraged to attend, should be developed. They are invaluable for educational purposes and serve also to broaden the resident staff in its outlook on the problems of life.

The record-keeping system of this branch should be comprehensive and a part of the general medical records. These records should be type-written with indelible ribbon, and free use made of photographs. Harmony of this division with other departments is very important for the clinical work of the colony.

Correspondence with relatives has a larger place in the matter of medical records of state institutions than is ordinarily the case in a general hospital, the period of residence in the state institution of the average patient being much longer than that of a general hospital patient. To facilitate ready reference, all correspondence regarding a patient and a carbon copy of replies thereto should be kept with the records of the particular patient.

A comprehensive plan, not confusing or difficult of access, supervised by the medical superintendent and kept in order by special clerks should

ensure completeness of records of medical work. The case histories should be kept preferably by vertical filing, permitting ready expansion, and should include photographs, summaries, and the use of cards to supplement the loose leaf. All making of notes should be systematic, thorough, scientific and, so far as possible, typewritten.

As Codman¹ says, case records are made for the following purposes: (1) scientific study, (2) for practical reasons, (3) for medicolegal reasons. He suggests a fourth use of case records—as data to form a basis for study to increase the efficiency of the hospital. Records should be reliable, immediate, adequate, permanent, and educational.

Fundamental in all work, but especially in a hospital of whatever nature, is a conscientious interest in its purposes. Without this, medical work and the recording of the same will be a sad failure.

While there must be cohesion and cooperation between the departments controlling medical records and accounting system, respectively, there is really little or no direct connection necessary in the state institution. The accounting system should be simple, recording the data pertaining to purchasing, receiving and distributing of supplies. Farm, garden, industries, clothing, repair and maintenance accounts must be kept according to varying state laws.

In the dietetic department the scope of work is general and special. In the large colony the former is mostly indicated, as a simple diet of broad application is what is sought. The dietitian with supervising nurses and physicians cooperating can readily carry out such a plan. The diet kitchen has a place for hospital and sick wards only.

A general kitchen is not feasible in the colony plan owing to wide separation of groups. The cottage or group kitchen, the former especially for better mental grades, is what must be made use of. In serving rooms conservation of food can go hand in hand with attention to appetizing service. Small dining-rooms permit continued classification.

Each epileptic must necessarily have his individual symptoms carefully considered before the proper treatment, especially as pertains to his diet, can be outlined. With the care indicated applied, any list of articles of food given is one to meet only general requirements and must be subject to modification for individuals. Diet for an epileptic must be simple in nature, excluding an excess of meats, all pastry, alcoholic drinks, cakes, sweets, small berries with hard seeds, cooked cab-

bage, and such articles of food as may apparently not be easily digested by any particular epileptic. All food should be properly masticated and close supervision extended at all times to overcome any tendency toward over eating. Menu gives moderate variety under system of simple dietary.

Equipment, Medical, Surgical and Physical.—While the completeness of regular surgical apparatus and furnishings in operating and dressing rooms in the institution hospital should be sufficient to meet ordinary demands of the simple life, an essential feature of the colony for epileptics calls for but a small part of such equipment in a colony where the patients are of much longer residence than in a general hospital. Special apparatus for doing unusual technical operations or venesection, spinal puncture, hydrotherapy, etc., should be available so far as may be required. The furnishing of the cottages of the colony should be complete. In some states the handicap of being obliged to use prison-made furniture of poor style and paucity of funds limits the carrying out of well-laid plans for simple but adequate furnishing.

Measures Against Influenza

A communication from Dr. Edward P. Davis, president of the Volunteer Medical Service Corps, gives a number of practical hints to be urged on the attention of families under the care of members of the corps, which are applicable everywhere in the present crisis. They include the following:

Guard against the epidemic by thorough cleanliness of houses, premises, clothing, utensils, and personal cleanliness. Avoid stirring up dust. Wash, scrub, sprinkle, and use soap and water thoroughly. Gargle the nose and throat with an alkaline antiseptic frequently. Cooperate at once to the fullest extent with the local, state, and national health boards. Urge, and cooperate in, preparing towns and cities for the epidemic by establishing emergency hospitals in suitable buildings, by districting communities, and by apportioning medical forces comprising physicians and nurses, so that no portion of the community is without medical care. Circulate and explain to the public the warnings and directions printed by the United States Public Health Service and by local health authorities. Urge the importance of fresh air and the avoidance of chill and overheat. Give no medicine and use no treatment which may depress the vital forces, especially the heart.

Two injunctions which are especially emphasized are, to avoid using supplies needed by the army and navy, and to postpone all surgical operations which are not absolutely necessary.

"The army and navy are fighting and conquering Germans. We must fight and conquer germs without taking anything away from the army and navy. Don't ask the army and navy for medical and surgical supplies. Use simple utensils for sterilizing; the simplest kinds of beds and bedding; make your own masks and dressings, and fight for yourselves.

"While the epidemic is on, do no surgical operations unless absolutely necessary to save life."

¹Codman, E. A.: *The Value of Case Records in Hospitals*, THE MODERN HOSPITAL, December, 1917, p. 426.

HOSPITAL ACCOUNTING

Accounts with Pay Patients—Superintendent's Ledger and Account with the Treasurer—The General Cash Book

BY CHARLES A. PORTER AND HERBERT K. CARTER, OF THE STAFF OF THE MODERN HOSPITAL

[Continued from October issue, p. 270]

PAY PATIENTS' CARD LEDGER ACCOUNTS

INDIVIDUAL Card Ledger accounts (Form 21) should be kept with each patient, showing the amounts paid in advance, board and attendance, special nursing and miscellaneous items, the balance due or paid in advance at the end of the month, and the overpayments made, which may or may not be refunded. These cards are numbered numerically from 1, beginning the first of

by patients. As many of these accounts are never refunded, they may be regarded as a part of the earnings of the hospital, and a certain amount be transferred from this account to miscellaneous hospital earnings by the proper Journal entry by authority of the Superintendent.

At the end of each month, when all entries have been made on the ledger cards, the totals of the overpayments and advance payments can be posted to their respective General Ledger accounts as well as the accounts receivable from patients at the end of the month. At the end of the year it is customary to prepare a schedule of these items, so that the directors may charge off as much as they see fit from the two accounts—

Fig. 17. General cash book. Actual size, 9½ by 14 inches. Bound book, with binding margin to be added at the center.

each fiscal year, for reference and to indicate directly the number of pay patients admitted to the hospital each month. The total days' treatment can also be figured from these cards if a check is wanted on the census reports.

Payments by patients are entered on a Cash Book and then posted to these individual accounts.

Overpayments by patients are payments made

Fig. 19. Pay patients' bill. Actual size, 8 by 6 inches.

Fig. 18. Combination cash and check book. Actual size, 12½ by 3 inches, five to a page. The headings appear only once at the top, the results being carried forward at the bottom and brought forward at the top of the succeeding sheets. Bound book, with binding margin to be added at left-hand sides.

by them for care not rendered and not to be rendered. These must be carried as a liability by the hospital, as they may be reclaimed at any time by the patient, since the institution has agreed to refund these "overpayments" when the patient is discharged. These must be carried to a General Ledger account entitled overpayments

overpayments and accounts receivable from patients.

OVERPAYMENTS BY PATIENTS

Refunds to patients are usually paid by check, but a much more satisfactory method is to make the refund in cash from the petty cash fund and obtain a receipt from the discharged patient, or a relative, or administrator on a petty cash voucher. This saves making out checks, and these receipts have only to be totaled and posted to the Ledger.

PAY PATIENTS TRANSFERRED TO FREE LIST

When a pay patient is transferred to the free list, a notation should be made on the Individual

Ledger card showing the date of the transfer. This will prevent a bill from being charged against a free patient. Laxity in matters of this kind will give the managers an idea that the superintendent is not a good collector.

SUPERINTENDENT'S LEDGER

The books previously described are the Superintendent's books of original entry, and are the records from which the accounts in the Ledger are posted. These accounts show the standing of that part of the hospital's financial affairs that are in charge of the Superintendent.

All entries from the Journal, Cash Book, Pay Patients' Ledger, and the Charge Register are posted separately or in total to these accounts.

1. CASH

The General Cash Book (Form 17) will show the balance of cash at any and all times, so that it is unnecessary to transfer this account to the Superintendent's Ledger, but the footings of this account must appear in all trial balances and the balance on the Balance Sheet.

2. ACCOUNTS RECEIVABLE

Dr.		Cr.
Total of previous months.....	\$.....	Total of previous months..... \$.....
Superintendent's account with treasurer.....	\$.....	Cash..... \$.....
For amount of bills accrued during the month as per the statement of hospital earnings and including earnings of ambulance, emergency ward, unclaimed wages, dispensary, accrued unclaimed overpayments, transferred to hospital earnings, and material sold during the month.		This includes all cash received by the Superintendent during the month on account of hospital earnings, and includes receipts for ambulance service, of the emergency ward, dispensary, material sold, and other miscellaneous receipts as per Cash Book.
Advance payments by patients.....	\$.....	Overpayments by patients..... \$.....
This item is taken directly from the Pay Patients' Ledger cards.		This account includes all overpayments transferred as per Journal entry 2 to miscellaneous hospital earnings.
Overpayments by patients.....	\$.....	Superintendent's account with treasurer..... \$.....
This item is taken directly from the Pay Patients' Ledger cards.		This account includes all uncollectible accounts receivable charged off during the month as per Journal entry 1.
		Advance payments by patients..... \$.....
		This item includes all accrued amounts due and charged from this account as per Pay Patients' Ledger cards.
Total.....	\$.....	Total..... \$.....

The difference in the totals of this account equals the accounts receivable at the end of the month.

3. ADVANCE PAYMENTS BY PATIENTS

Dr.		Cr.
Total of previous months.....	\$.....	Total of previous months..... \$.....
Accounts receivable.....	\$.....	Accounts receivable..... \$.....
This item includes all amounts due, accruing during the month and charged from this account to hospital earnings as per Pay Patients' Ledger cards.		For advance payments by patients as per Pay Patients' Ledger cards.
Overpayments by patients.....	\$.....	
This item includes all advance payments of previous months charged to overpayments as per Pay Patients' Ledger cards.		
Total.....	\$.....	Total..... \$.....

The difference in the totals of this account equals the advance payments by patients as shown on the Balance Sheet.

The accounts usually found in this book are cash, accounts receivable, superintendent's account with the Treasurer, bills payable, overpayments by patients, advance payments by patients, discounts, materials, supplies, and unclaimed wages. The footings of these accounts are used to make up the Superintendent's Trial Balance and the balance for his Balance Sheet.

The following examples will illustrate the manner in which the entries are to be posted to the various accounts. Explanations are given in detail to show exactly how the items are handled.

The description of each entry is merely the name of the other account under which this same transaction appears. It is well to remember here that "every debit must have an equal credit."

4 OVERPAYMENTS BY PATIENTS

DR.				CR.
Total of previous months.....	\$.....	Total of previous months.....	\$.....	
Cash.....	\$.....	Accounts receivable.....	\$.....	
For overpayments by patients refunded during the month as shown by the Cash Book.....		Overpayments by patients as per Pay Patients' Ledger cards, accrued during the month.....		
Accounts receivable.....	\$.....	Advance payments by patients.....	\$.....	
Accumulated overpayments transferred to hospital earnings as per Journal entry 2.....		Advance payments of previous months charged to overpayments as per Pay Patients' Ledger cards.....		
Total.....	\$.....	Total.....	\$.....	

5 MATERIAL ACCOUNT

DR.		CR.	
Total of previous months.....	\$.....	Total of previous months.....	\$.....
Purchases.....	\$.....	Accounts receivable.....	\$.....
As shown by the material account in the Charge Register.....		Amounts due for sales of material during the month as per Sales Book or Ledger accounts.....	
Superintendent's account with treasurer.....	\$.....	Cash.....	\$.....
Surplus amount of material as found by inventory and debited to this account as per Journal entry 3.....		For cash sales of material as per Cash Book.....	
		Superintendent's account with treasurer.....	\$.....
		For loss or depreciation of material as shown by an inventory.....	
Total.....	\$.....	Total.....	\$.....

The difference in the totals of this account equals the value of the material on hand at the end of the month, as shown by the physical inventory, or by the perpetual inventory, if it is kept as it should be. The supplies account is kept in this same manner.

6 SUPERINTENDENT'S

DR.		CR.	
Total of previous months.....	\$.....	Total of previous months.....	\$.....
Current expenses.....	\$.....	Accounts receivable.....	\$.....
As shown by the Charge Register and statement of same.		For amounts of bills accrued during the month, including all hospital earnings.	
Capital expenditures (enumerate).....	\$.....	Cash.....	\$.....
As shown by the Charge Register and a statement.		For all cash received from the treasurer during the month.	
Cash.....	\$.....	Discount.....	\$.....
For receipts of cash as per Cash Book remitted to the treasurer.		The amount of discounts accrued for the month and transferred to this account as per Journal entry 7.	
Accounts receivable.....	\$.....	Material.....	\$.....
Accounts receivable charged off as uncollectible during the month as per Journal entry 1.		For surplus amount of material found by inventory and transferred to this account by Journal entry 3.	
Material.....	\$.....		
For loss or depreciation charged from this account as per Journal entry 4.			
Total.....	\$.....	Total.....	\$.....

The difference in the totals of this account shows the balance as on the Balance Sheet. This account must agree with the Treasurer's account with the Superintendent.

7 UNCLAIMED WAGES

DR.		CR.	
Total of previous months...	\$.....	Total of previous months.....	\$.....
Cash.....	\$.....	Unclaimed wages accrued during the month.....	\$.....
Unclaimed wages paid during the month.....	\$.....		
Superintendent's account with treasurer.....	\$.....		
Unclaimed wages transferred to hospital earnings as per Journal entry 5.....			
Total.....	\$.....	Total.....	\$.....

SUPERINTENDENT'S MONTHLY REPORT TO THE
TREASURER

The Superintendent should make a report to the Treasurer as early in the month as possible, giving a copy of his account with the Treasurer and a copy of appropriations from special funds to meet current expenses, his Trial Balance, and Balance Sheet. (See Form 24.)

SUPERINTENDENT'S MONTHLY REPORT OF EXPENSES,
REVENUE, AND STATISTICS

In hospitals as well as in commercial institutions the general custom has been to have a yearly report and audit made. At this time inventories were taken and the profit and loss account completed. During the last few years the fact that it was not necessary to wait until the end of the

year to know the standing of the concern and the condition of the business has been acknowledged. It is now becoming the custom to make monthly statements of expenses and revenues, assets and liabilities, and surplus and deficit. These reports enable the Board of Managers to keep a finger on the pulse of the financial arm of the institution, to plan to meet obligations, to plan future policies, and to direct curtailments of expenses when necessary, instead of waiting until the end of the year, when the financial affairs of the hospital may be hopelessly involved.

Form 25 shows a form of Treasurer's Monthly Expense and Revenue Statement, and Form 26 shows the Treasurer's Monthly Surplus and Deficit Account and Balance Sheet.

[To be continued.]

A SUCCESSFUL PRIVATE INSTITUTION FOR GIRLS

Modern Fireproof Building Provided at Moderate Cost—A
Home Free From Institutional Atmosphere

The women of Bloomington, Illinois, who have charge of the Girls' Industrial Home have recently completed a very wonderful building and financing project, described in the *Institution Quarterly* as follows:

They have erected and furnished a new fireproof building, 100 by 40 feet, planned on the most modern lines, furnished it throughout, and paid for it in cash from funds voluntarily contributed by the people of Bloomington and McLean County.

In these times of high prices of building material and labor, it is difficult to understand how a building of such size and excellence of construction could be had for so small a sum of money, namely, \$26,000. The building will accommodate seventy-five girls.

The institution is organized under the Industrial School Act and is twenty-nine years of age.

The purpose of the home is three-fold:

First—To provide a home for dependent and homeless girls of all ages under eighteen.

Second—To furnish a boarding place for girls having some friends who will be responsible for their support while in the home.

Third—To secure permanent homes in responsible families, either by commitment or by legal adoption.

For years it occupied rented quarters, but from the start its work has been so efficiently done that it has appealed to the generosity of the local public and today it owns three acres of valuable land in the city of Bloomington and the new building, all of which is entirely free from debt, and valued conservatively at \$35,000. The new building is fireproof. It is liberally equipped. All the living rooms, working quarters, and dormitories are light, well ventilated and plainly but well finished. It has its own heating plant, and its own laundry.

The need of such an institution in this locality may be seen from the fact that since its inception it has annually provided a home and care for from twenty to sixty girls, and in that time hundreds of girls have been helped to become good and useful women through the Christian influence of its home life, while scores of families have been brightened and blessed by the little bright-eyed baby or girl they have taken from the home.

It is the aim of the management to make the home not institutional in any way. There are no uniforms for the children; there are no rules, other than those of the home; there are no locks and bars.

The children go to the public school like other children, suitably dressed; they go to church and Sunday school; they go to picnics; they play and visit just as do the children whom the world calls fortunate.

A kindergarten training is also provided, by volunteer workers, for those under school age. Under the direction of the heads of the various departments, the children are all given such training in domestic science as will enable them to become useful members of the families in which they may be placed, as well as self-supporting when they attain the age limit of the home. They are also required to assist in the care of the grounds, garden, chickens, and cows.

The doors are always open to the homeless child. Always and at any time, she may come in and be cared for, educated, taught useful arts, and remain as long as it is necessary for her to stay.

The corporate powers of the home are vested in a board of sixteen members, four of whom are the officers, who are elected annually by the board of managers.

Alder Hey, A Military Orthopedic Hospital

Most of the British orthopedic centers are palatial establishments, either converted modern poor law hospitals or asylums, or barrack hospitals built specially for the purpose. They are situated in spacious grounds, providing ample room for the erection of auxiliary buildings. They have been established for the most part in university towns.

Alder Hey Hospital at Liverpool was the first military orthopedic hospital established. It is situated about five miles from the center of the city, almost in the country, on rising ground, with plenty of sunshine and fresh air. It can accommodate 800 patients. In the hospital grounds a number of curative workshops, a new gymnasium, electrotherapeutical and hydrotherapeutical establishments and an operating theater have been erected. An important feature is the massage department where 500 patients are daily treated by 29 masseurs and masseuses. The primary object of the curative workshops is improve the condition of muscles or to increase the range of movement in a stiffened joint.

THE BAHAMA GENERAL HOSPITAL AND ASYLUM

A Progressive Hospital Group Which Includes an Infirmary, Asylum, and Leper Compound—Staff Almost Entirely Native

By MRS. T. MILNE (FORMER MATRON OF THE BAHAMA GENERAL HOSPITAL), SUPERINTENDENT OF THE JOHN SEALY HOSPITAL, GALVESTON, TEXAS

THE Bahama General Hospital and Asylum is a typical colonial hospital, containing about two hundred beds. It includes a male and female hospital (Alexander Hospital) and a male and female infirmary (Victoria Jubilee Infirmary).

The grounds about it are spacious and, lying on

grounds, as is also that of the superintendent. Situated on the top of the hill are the male and female lunatic asylums, the isolation wards and leper compound, the latter being entirely apart from all other buildings. Directly in front of the gates, at the end of the drive and the top of Pine

Avenue are the administrative buildings, and matron's quarters. The hospital itself is a nice new building, but its sanitary conditions are by no means modern. Although the commissioners are anxious to make improvements, they have been unable to do so, for money is not plentiful in the Bahamas now.

The superintendent, a man, has full charge of the business side of the institution. The resident surgeon has been connected with the institution several years and consequently knows the patients and conditions well. The staff includes two European graduate nurses, a "matron" and a "sister." The latter has charge of the hospital



Fig. 1. Male and female hospital.

the side of a hill, command a beautiful view of the sea, which, with all its different colors, tends to cheer the patients and help them get well. The tropical flowers and Victoria palms make the place look more like a home than a hospital. The resident surgeon's home is within the



Fig. 2. Resident physician's home.



Fig. 3. Matron's quarters and administration building.

and nurses and also superintends the asylum, infirmary, isolation wards and leper compound. Two graduate native nurses act as night supervisor and charge nurse. At present there are nine native female nurses in training, all of whom are most anxious and willing to learn. They are

taught their theory by the matron and the practical work by the "nursing sister." The curriculum includes theory and practical nursing, drugs and solutions, ethics, surgery, anatomy, physiology, obstetrics and diseases of children. The hours of duty are from 6:30 a. m. to 7 p. m. daily. On Sundays these nurses are off duty alternately from 9:30 a. m. to 2:30 p. m. and from 2:30 p. m. to 10 p. m. They are also off duty one half day each week and three hours each day. The matron and sister have comfortable quarters, and all nurses and attendants are well taken care of. The female nurses attend solely to the female patients, while the male wards of the hospital are staffed entirely by male attendants (one head and three assistants, one of whom is for night duty only). Male nurses have the same hours of duty and off-duty as female nurses. A holiday of two weeks is allowed to each nurse and attendant yearly.

The Victoria Jubilee Infirmary is for the aged and infirm, male and female, who are not very ill, those needing medical attention being transferred to the hospital. The infirmary is staffed by a female native graduate nurse with an assistant who is one of the nurses in training. The old women do the mending when they are able. The male infirmary, which is quite new and a credit to the institution,



Fig. 4. Male and female infirmary.

has one head attendant and an assistant.

The asylum receives both male and female patients. The sexes occupy different buildings, both of which, standing at the top of the hill, overlook the city and the sea. One female head attendant and her four assistants are kept busy looking

after the twenty patients who are now in the female division of the asylum. The male asylum is quite new and has at the present time twenty-five patients. It is staffed with one male head attendant and five male assistants. All the patients who are sufficiently quiet are allotted a certain amount of work, hewing wood, carrying water, or attending to the hospital grounds.

The isolation wards are away from the hospital buildings and are used for the dirty and infectious cases. The male and female lepers' compound wards stand alone and apart from all other buildings. Five male patients are in the compound at present. The doctors and matron visit



Fig. 5. View showing male lunatic asylum at left and female at right.

these wards at least twice a day, administering treatments which consist chiefly of those Indian oils said to be effectual in all cases of leprosy. The mortuary is away and in a separate building; and even on a hot day it is quite cool.

The patients are mostly natives from Nassau



Fig. 6. Leper compound.

and the surrounding islands.

Three days a week out-patients come to see the doctors and, if very poor, are given both rations and medicine. Before supplies are given, however, the relieving officer visits all cases to inquire into home conditions. The patients wait for their medicines in the dispensary, and many are the kinds of bottles brought to put the medicine into.

The conditions and advantages surrounding the where war and trouble are unknown.



Fig. 7. Group of nurses of the Bahama General Hospital.

natives in this colony are such that they should be happy in their land of sunshine and beauty. The natural surroundings are ideal for producing a spirit of cheerfulness, conducive to recovery. Nassau is a very beautiful city, and very Spanish in appearance. The exquisite blue sky and sunsets are delightful to behold; and, with the wondrous sea of many colors, one can imagine himself in fairyland,

NEW FOUR-PATIENT COTTAGE AT BARLOW SANATORIUM

Simplicity of Design Combined With Comfort and Practicability—Low Cost of Maintenance and Ample Supply of Sunlight and Fresh Air Assured

BY WALTER C. KLOTZ, M.D., RESIDENT PHYSICIAN, BARLOW SANATORIUM, LOS ANGELES, CAL.

This cottage is designed to accommodate four patients and has been adopted as the present standard plan of construction in place of a former two-patient type. This larger unit has been found more economical, and the ratio of one bath and toilet to four patients has been found adequate. At the same time, none of the advantages possessed by the two-patient plan have been sacrificed.

As shown by the floor plan, each patient has an individual sleeping porch and comfortable dressing room. The sleeping porches are all placed at corners of the building, offering a south-

building, except for a part of the south side. This open porch can be used in the daytime and offers a choice of either sun or shade, as may be desired, according to the different seasons of the year. Each dressing room is provided with a built-in wardrobe and a chest of drawers. Between these is placed a white enamel stand for washbasin and above this a shelf for toilet articles. Between the dressing rooms is located a shower bath, with dressing room and bench, a toilet, and, in an open recess, a slop-hopper, which is used also as a dental lavatory. The shower and toilet compartments, as well as each one of the dressing rooms, have a good-sized window placed in the wall on the north side, which supplies ample light and air. In addition, screened ventilator openings are left in the ceiling of the dressing rooms and sleeping porches. These lead into the attic space which is ventilated by means of louvers placed in the gables.

The long interior corridor is lighted and ventilated by two windows on the south side near each end. The sleeping porches are provided with copper screens and also with canvas awnings on each of the open sides, for use in stormy weather.

Hot water for the shower, bath, and hopper are provided by a solar heater. The cottage is lighted by electricity.

The construction is substantial and permanent. The foundations of the cottage and the open porches are eight-inch concrete walls placed on



Fig. 1. New four-patient cottage at Barlow Sanatorium, Los Angeles.

ern and also an eastern or western exposure. This insures ample sunlight during a part of the day and good cross-ventilation, besides affording a considerable degree of privacy. An open porch or terrace five feet wide extends all around the

*The illustrations accompanying this article are presented by courtesy of the *Journal of the Outdoor Life*

ample concrete footings. The space within and between these walls is filled solid and tamped with earth, over which is placed a two-inch cushion of sand. Upon this is laid a three and one-half inch layer of concrete, which forms the floors of the cottage and porches. The building itself is of good heavy construction. The outside sheath-

necessary in our climate. In colder climates a plant for heating the dressing and bath rooms could be accommodated in a small excavated basement entered from the outside. A coal or gas heater for heating water could also be installed in localities where solar heaters would not be adequate.

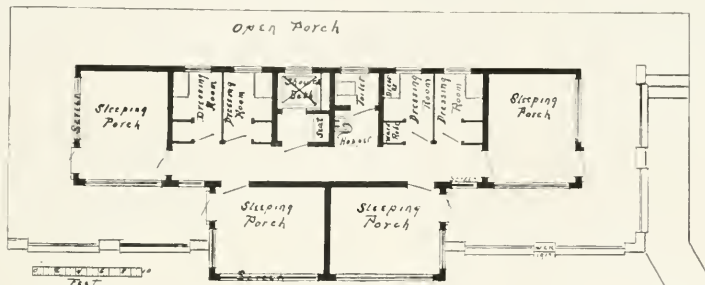


Fig. 2. Floor plan of the four-patient cottages now being used at Barlow Sanatorium. The cottages were designed by Mr. B. B. Bixby, a Los Angeles architect, and three of them have been built under his supervision.

ing of rough boards is covered with metal lath and cement stucco plaster, which is also applied as a finish coat to the foundation walls. The floor is of broken tile. The interior is ceiled with matched redwood finished in enamel paint. A composition sanitary base is carried out for six inches above the floors.

The cost of this cottage a year ago was \$2,500, including all furniture, equipment, plumbing and wiring. The cost at the present time would be at least \$2,750.

No heating plant is provided, as this is not

The ground plan is, of course, adapted to different methods of construction, and the cost would be increased or diminished correspondingly. The important feature, and the main object sought, was to provide a four-patient unit for ambulant cases, combining the greatest degree of comfort and privacy with ample facilities for fresh air and sunlight, a simplicity of design that would keep down the first cost and involve the least amount of service, and, at the same time, a class of construction that would insure a low cost of upkeep for repairs and maintenance.

A PRACTICAL REMEDY FOR HOSPITALIZATION

The Vancouver General Hospital Organizes a Plan to Lessen the Number of Days' Stay of Patients in the Hospital

By MALCOLM T. McEACHERN, M.D., C.M., Superintendent Vancouver General Hospital, Vancouver, B. C.

At a recent meeting of the medical board of the Vancouver General Hospital I took up the question of patients staying in the hospital too long, some of whom were becoming hospital. A committee appointed to confer with me found the following conditions to exist:

1. Many patients, usually indigent people, paying little or nothing for their accommodation, were staying in the hospital longer than they should, and thus constituting a loss to the hospital.

2. This fact influences the medical attendant to keep them in the hospital during the time of convalescence, as they have no means to support themselves at home and are not yet able to work. Another factor is that many of them live in surroundings unfavorable to convalescence. Others still need dressings, treatment, special diet, etc.

3. In reviewing cases of this type, our committee found many in which the length of stay in the hospital was apparently quite unjustified by the condition present; many patients that could do equally well on outdoor treat-

ment; some whom their medical attendant saw only at infrequent intervals, and so on.

4. Careful analysis of reports from the leading hospitals in Canada and the United States show that the average length of stay in hospitals is usually 14 to 16 days, whereas ours is 19 to 20 days. We are keeping our patients in too long.

5. It may be pointed out that this state of affairs affects adversely (1) the hospital, (2) the patient:

As regards the hospital: (a) This institution is primarily designed for the treatment of active cases of illness. The hospital should handle only cases that are actively progressing toward recovery or toward death. Static cases, with permanent or long-standing disabilities, are not suitable cases for hospital treatment. This hospital has a thoroughly efficient convalescent home, an outdoor department, and a social service department. One or the other of these departments can be called into service as necessary, and cases can be placed with the most ample consideration of their family and financial circumstances. (b) Again, this hospital has a continual deficit which, as pointed out, is only increased by this type of patient. If at all possible, this should be stopped, and the hospital has a perfect right to demand the co-operation of the medical men in this.

From the patient's point of view two cases may be quoted:

Case 1. Mr. J. C., in hospital for many weeks, had no money, some worry; complained of indefinite pain. Seemed to have developed into a profound neurasthenic. Doctor said nothing was wrong with him as far as he could find out, and discharged him. The patient came to my office furious at being discharged when he was so ill. I could not get rid of him from here, so I asked his doctor if I might take him out to the annex at Marpole. He consented to let him go. I took him out, got him a room with another patient who was quite well, had him come back daily for high frequency, etc. The first night there they had a lively concert and the next night another, and he was all right in three or four days. Now he is work-

6. That the medical superintendent interview the doctor and if necessary employ a letter ("Form B").

7. That after a case has been passed on by the medical board, the medical superintendent shall have power to act forthwith on their recommendation.

8. That medical men be requested at the earliest opportunity to give to the head nurse of the ward the diagnosis of the case; this to be written on the front of the chart, for use as shown above. If not given within twenty-four hours, this should be obtained by the head nurse by direct request.

FORM A

To be handed in to the Superintendent's office every Monday morning by the nurse in charge. For all patients.

THE VANCOUVER GENERAL HOSPITAL
Weekly Report of Patients in the Ward

Week ending..... Ward.....

Name	Admitted	Number of days in hospital	Diagnosis	Doctor	Number of visits made by doctor during week	Remarks

ing hard. This man was in the first stage of hospitalization.

Case 2. M. A. L. was brought to the Vancouver General Hospital in a reduced physical condition from lack of nourishment and hygiene. After a few weeks he was transferred to the annex at Marpole for further convalescence. He had been seen only occasionally here by his attendant. Routine dental examination at the annex—an advantage the patients there have over the patients in the main hospital—revealed extensive teeth trouble. This was at once attended to and the man was discharged two or three weeks later and is now back to a productive life.

Others might be cited to show that in the patient's interest there is need of a remedy for the present state of affairs.

As a remedy for the foregoing our committee suggested the following:

1. That a medical board of revision (of three members) be appointed from the medical staff of the hospital, or as they might see fit.

2. This board to consist, preferably, of one member from the consulting staff and two members from the active staff, the medical superintendent to attend its meetings and act in an advisory capacity.

3. (a) That this board meet twice a month, or at the call of the medical superintendent, *pro re nata*, to review and examine any cases brought before them by him and bring in a recommendation as to their disposal. (b) Some regular form, e. g., "Form C," to be filled out by the board in each case.

4. That the medical superintendent have made to him a weekly report from each ward of all patients in the ward ("Form A").

5. (a) That he pick out such cases as seem to him to have been in the hospital longer than necessary or advisable, and get in touch with the doctor in charge. (b) That all cases in the hospital ninety days or over come before the medical board automatically.

FORM B

.1918.

Dear Doctor:

You have a patient named John Smith in Ward "A." This patient has been in the hospital since January 1, 1918, and is not receiving active treatment. In the best interests of the patient, and as the hospital is urgently in need of beds, can this patient be—

Discharged.

Referred to Outdoor Department.

Referred to Social Service Department.

Transferred to the Annex at Marpole

Failing to hear from you, the above-named patient will come automatically before the Medical Board of Revision at their next meeting.

Yours very truly,

.....
General Superintendent.

FORM C

REPORT OF MEDICAL BOARD OF REVISION

Name
Admitted
Address
Pay or Non-Pay
Number of days in Hospital.
Diagnosis
Treatment
Progress
Examination reveals
Recommendations, ...
(Signed)

(Signed)

Chairman Medical Board of Revision.

Member Medical Board of Revision.

Member Medical Board of Revision.

Dated this.....

This entire system has been taken before the Vancouver Medical Association and their cooperation asked for. It is now in force and has already given good results, many of the doctors volunteering to have the medical board of revision sit on their cases.

RELATION OF LABORATORIES TO HOSPITALS*

Improvement in Methods and Equipment of Pathological Laboratories—Laboratory Workers Becoming Clinicians—Functions and Values of Laboratories—Specialization in the Laboratory

By WILLIAM CARPENTER MACCARTY, M.D., MAYO CLINIC, ROCHESTER, MINN.

By the term "laboratory," of which I am to speak, I mean a room, building, or workshop especially fitted with suitable apparatus for conducting investigations in any department of science or art.

This term includes the whole laboratory, or series of laboratories. According to my own conception of efficiency in the science of medicine, the entire hospital is the laboratory and every worker in the hospital is a laboratory worker. Personally, I would not work in a laboratory for the study of the ills of man which did not include the whole hospital, to all parts of which I had access. This does not mean that the one in charge of laboratories should desire or expect to dominate or in any way control all of the departments of the hospital, but it does mean that only by such breadth of vision can one fully appreciate our problems, although each one of us may be especially active only in one phase of the big problem.

A few years ago, and perhaps even today in some hospitals, the word "laboratory" conveyed and conveys the idea of nothing more extensive than a small room, usually in the basement, for the examination of urine, or perhaps a place where some curious intern might stain bacteria.

In some hospitals, as we progressed, the term became more extensive and was associated with a small, usually the smallest, room somewhere in the morgue. This was the pathological laboratory. It was a kind of customs house where the last examination of earthly belongings was made preparatory to sending the body on its long journey back to earth.

From such humble surroundings there soon evolved a building known as the pathological laboratory. This still remained some distance from the main hospital and always contained the morgue. It was a kind of gate between the physicians and the undertaker.

I have always believed that this association with death takes the initiative of life out of many a good scientist.

All of these conditions are changing; here and there throughout the hospital one finds today rooms equipped with various kinds of apparatus—apparatus for the purpose of studying the liv-

ing, not the dead. The methods and value of the laboratories have not only invaded the whole hospital, but have invaded every branch of human welfare. Laboratory workers are becoming clinicians who are specializing in the utilization of certain apparatus for the purpose of preventing, curing, and ameliorating the ills of their fellow man. They are already an economic factor in the progress of mankind. The time is too short for me to enumerate statistically all of the laboratory activities of man and their value as such a factor in human progress.

In the practical hospital which administers to the immediate demands of masses of people, the functions and values of laboratories may be summarized briefly. They are:

1. The determination of causes of death, the actual cause being often clinically unknown.
2. Assistance in the making of pre-mortem diagnosis by means of extensive examinations of urine, sputum, blood, stools, excretions, secretions, and tissues microscopically, bacteriologically, physically, and chemically.
3. The actual making of pre-mortem diagnoses such as result from examinations of neoplasms, and the determination of types of diseases from bacteriological examination and from metabolic status.
4. The determination of the extent of therapeutic procedure by means of examination of urine and blood, feces, sputum, and metabolic status during course of treatment.
5. Prevention of disease, by vaccination against smallpox, typhoid fever, tetanus, diphtheria, cholera, etc.
6. The obtaining of prognostic data by determination of probable duration of life depending upon microscopic evidence of malignancy or benignancy of neoplasms and character of metabolic condition.

One of the essentials of our definition of a laboratory consisted of the term "apparatus." This term is so broad that it includes everything from the finest microscope or most accurate chemical balance to the most insignificant article in a diet kitchen. There is no place to draw a line between what is apparatus and what is not. Therefore, I say again that the entire hospital is the laboratory, or a series of laboratories.

In carrying out the six functions which have

*Read at the Third Convention of the Catholic Hospital Association, 1918.

just been mentioned, the instrument which we call a microscope has played a most important role, one so important that most laboratories and workers are usually associated with it. This is only one of many, but its importance may be seen in the fact that during the month of July in our clinic there were 7,706 absolutely necessary microscopic diagnoses made on the 4,752 patients who were registered during that month. This averages almost two examinations for every patient. Of this number of patients, there were 4.3 per cent which required a microscopic tissue examination in order to establish a positive diagnosis. Of 1,699 patients who came to operation during that month, 61 percent produced surgical specimens, 20 percent of which required a necessary microscopic tissue diagnosis.

It might be stated here that the clinician has a percentage of diagnostic accuracy when he makes a positive diagnosis of 95 percent. As a matter of fact, however, 22.6 percent of the cancers of the breast which pass through his hands are discovered positively in the surgical laboratory. When our clinicians make a diagnosis of carcinoma, or inflammation, in the breast, they are correct in only 49 percent.

These figures, startling as they are, compare favorably with the results in other organs of the body, and serve to prove the necessity for immediate tissue diagnosis in connection with surgical procedure unless the surgeon wants to submit his patient to two operations (thus doubling the surgical risk), or to take a chance on his ability to diagnose tissue grossly. If he does the latter, he is assuming a proficiency in tissue diagnosis which statistically he has no right to assume, and is submitting his patient to the ravages of his own conceit or ignorance. In the laboratory of surgical pathology in our clinic, men who have spent their lives doing nothing else but examining and studying tissues grossly and microscopically in their relation to the patient under the most favorable circumstances, must of necessity examine over 20 percent under the microscope before a positive diagnosis can be made.

These figures represent the efficiency which has followed a careful whole-time study of over a hundred thousand surgical specimens during a period of training with the microscope of twenty-four years. Perhaps interns today, whose opinions are relied upon in many hospitals for tissue diagnosis, belong to a race of supermen. If they do, they soon fall from that mighty position when in the environment of ordinary men who have had large experience. The mistakes of these well-meaning and conscientious young men should not be counted against them. The fault rests upon

the youthfulness of the system of medical science which you and I have had as a part of our inheritance. We were born too soon. We were born at the period of transition of medicine from an art to a science, and such transitional periods in nature are usually filled with mistakes.

Great laboratory leaders in this period have been busy discovering and establishing new principles. They have been too busy to associate with the details of clinical medicine. Great physicians, on the other hand, have been too busy ministering to the immediate sufferings of humanity to spend time in laboratories. Such isolation at this stage of our development, associated with the duties of teaching students, has been largely responsible for the slowness of cooperation of laboratory methods and facts with clinical methods and facts.

There is one other factor which I hesitate to mention, but the good of humanity demands that some of the more fortunate of us not only mention it, but clearly state the facts for the benefit not of ourselves, but of others.

The question of compensation for laboratory workers is a vital one, so much so that there is a great and almost disastrous dearth of well-trained laboratory experts. They are not being made for the simple reason that young men must live and allow their families to live social lives commensurate with their intellectual training. Money, I am thankful to say, has never been the desire of the medical profession, but if the practitioners of medicine continue to look upon laboratory functions as being in no way equal to their functions in rendering service, the medical profession will either become purely commercial or it will be threatened by the same conquest which now threatens the social world as a whole in the establishment of social justice to all.

It behooves leaders of both purely clinical and laboratory methods of rendering service to cooperate not only in their services, but also in their compensation, whatever that compensation may be. This can be done throughout the medical profession. It is being done by some leaders in a just, honorable, equitable, ethical, and gentlemanly manner to the satisfaction of all parties, especially the patient who reaps the reward of the highest type of efficiency.

What I have said briefly and generally so far is in the nature of destructive and constructive analysis.

From a purely constructive point of view, time permits only certain suggestions which are derived from isolated experiments which have been carried out successfully in a few hospitals with which I am personally acquainted. The experi-

mental stage is passed and it only remains for us to summarize the generalizations.

1. Some leaders in the medical profession have selected young men who have manifested natural inclination and capacity for laboratory methods of investigation from research and clinical points of view and encouraged them by opportunities and just earthly compensation. As a result these young men are enthusiastically striving to advance and are actually advancing the science of medicine along all lines for the sake of humanity.

2. Some trustees of hospitals with whom I am acquainted have been successful and efficient business men from the point of view of methods and some of these men are realizing that human progress is dependent absolutely upon the health and happiness of mankind. Such men are, by constructive and efficient methods, organizing hospitals for the science of medicine, fully equipped structurally and functionally for efficient service in all branches which are productive of efficiency.

3. Some laboratory experts are beginning to prove statistically the inefficiency of some of our old methods and the efficiency of newer methods of intimate cooperation of departmental science in the practice of medicine in hospitals.

4. The general public is beginning to demand laboratory examinations, a fact which is evidence that the layman has begun to learn that the practitioner of medicine must be something more than the possessor of a pleasant personality and a capacity to arouse blind faith.

In conclusion I wish merely to state that as one trained in laboratory methods and intimately in association with clinical medicine, I am convinced that no hospital has reached the highest efficiency which has not coordinated the best laboratory methods with its rendition of service to its patients, and that no practitioner can render the most efficient service who does not call laboratory methods into consultation.

Unfortunately, we have not enough well-trained laboratory men, but they can be made only by your recognition of their value and your material and moral assistance.

I regret that time does not permit me to present to you the vast statistics which I have at my disposal to prove accurately the relationship which does exist in some hospitals and must soon exist in all hospitals.

My mission at this time is one only of stimulation. You who are eager to render the best service will look for the statistics. Your presence here has already proved your desire for improvement. You are ready for the big conception that this is not only a day of specialization, but a day of the coordination of specialization for the cure,

amelioration, and prevention of disease; and the coordination to attain these ends can be carried out only in hospitals which I still conclude are nothing but laboratories.

Now, let me answer from experience the questions "Who should direct them?" and "Who should do the technical work?"

True science knows only the greatest efficiency as a goal; and the greatest efficiency in laboratory direction is not confined to any sex, race, or religion. It deals largely with the personal equation of accuracy of observation, correlation and generalization.

It is logical to suppose that an individual who has been especially trained and has had a large experience might render greater service than the untrained and inexperienced. It is also logical to suppose that any individual who devotes his whole time to a subject will in the same number of days be more efficient. It takes time to train, and time and experience travel in parallel lines. It seems logical to suppose that an individual who has experience and is trained would make a more efficient director than the experienced or partially experienced, untrained, or partially trained individual. Since laboratory methods are becoming more numerous and are changing, and the facts are rapidly increasing, there is no individual who is trained completely. It is purely a relative matter.

My advice is simply this: Obtain for your hospital the best-trained and the most experienced young man or woman who has great possibilities of growth. Never take a finished product. I have a suspicion, inferring from the subject presented to me, that you really want to know if your laboratory director or worker should be a practitioner, and my answer is that he should serve only as a consultant.

The question as to who should do the technical work is a matter to be dealt with just as was that of the director. Any individual who is physically and mentally fit can do any technical work in any laboratory. In our own laboratories we have girls and boys as technicians. There is absolutely no reason why sisters cannot do the technical work of a laboratory just as well as they do the numerous other important technical things which make a hospital a success.

In conclusion allow me to express publicly our great appreciation of our own good sisters, led by Sister Mary Joseph, who have at all times heartily cooperated in every possible way in our efforts to serve humanity best.

By examining the tongue of a patient, physicians find out the diseases of the body, and philosophers, the diseases of the mind.—Justin.

FROM OUR FIELD EDITORS' NOTEBOOKS

A Marvel of Modern Architectural Landscape Gardening Around a Washington Children's Hospital—A New York Hospital Which Has Sent One-Half Its Staff to the Front—Attractive Features of Some Indianapolis Hospitals—Some Interesting Philadelphia Hospitals

The Children's Hospital, Washington, D. C.

The front of the hospital is a long old brick building; that is, it seems to be brick, as far as one can judge from the glimpses one catches of it here and there through the ivy that covers it almost completely. Over the front porch a sign reads, "The Children's Hospital, Incorporated 1870."

The ceilings of the old buildings are very high. An old walnut bannister leads to the first floor. On the right of the hall is a full wall length memorial tablet in brown and white marble which looks strangely like the entrance to a tomb. On the same side of the hall is the reception room, a parlor of true colonial solemnity, brightened by a bowl of roses of a vivid living pink. The hospital blooms everywhere with fresh cut flowers, which are sent several times a week by the Agricultural Department of the Government.

The older buildings are used almost entirely for colored patients. There were dark-skinned babies and children, black and yellow and almost white. The screens on the windows of the wards were for the protection of up patients, and the creeping ivy on the outside of the building had climbed on the meshes of the wire until it almost covered the windows.

The newer buildings of the hospital are constructed about a court, and are connected by passageways. These connecting corridors are covered by stone walked balconies, surrounded by stone railings. The new buildings blend in a perfect harmony with the older ones.

The court is known as the Memory Garden, and is a marvel of modern architectural landscape gardening. In the center a fountain plays lazily in its stone basin. Stone seats of pure design are scattered around the circular bricked courtyard. The chimney of the heating plant facing on the court is covered with ivy almost to the top, and the same ivy winds around the side walls. Thick shrubs and plants make shade and seclusion and an ideal resting-place. On the outside of the buildings are roomy lawns, and shade trees give a pleasant note to the children's playgrounds.

In that part of the newer buildings known as the white medical and surgical wards, the mattresses and springs are removed from the cribs in the warmer part of the year and replaced by stretched canvas hammocks. They have proved to be more cleanly and comfortable during the summer months.

The day I visited the hospital, the weather was damp and cloudy and a cozy grate fire burned in the nursery to warm the chilled air for the babies.

One of the new pavilions has endowed suites for mothers and children. Each suite consists of a mother's room, a bathroom and a room for the child. At the end of each of the corridors there is a mother's dining room and a sun-parlor.

The Children's Hospital affiliates with the Garfield Hospital and the Eye, Ear, Nose and Throat Hospital of Washington to complete the education of its nurses in training, and with the Homeopathic and George Washington Hospitals to furnish special training in the diseases of children for the nurses in these hospitals.

The lower floors of the new building are used for dispensary and out-patient department, and baby welfare station. About forty patients a day are treated here. A social service nurse is employed. Medical officers of the government hospitals are assisting in the radiographic work of the out-patient service.

Miss Charlotte Estes is acting superintendent of the hospital at present, relieving Miss Woodworth, the former superintendent, who is now chief nurse of a convalescent hospital in France.

Roosevelt Hospital, New York City

Roosevelt Hospital was founded under the will of James H. Roosevelt, and incorporated in February, 1864. It occupies the block of ground between Fifty-eighth and Fifty-ninth streets, between Ninth and Tenth avenues in New York.

During the year of 1917, 30,225 persons were treated in all departments of the hospital.

A base hospital unit with a personnel representing about one-half of the staff of physicians and nurses of the Roosevelt are in service in France. Mr. Clarence H. MacKay furnished standard equipment for this unit. A late report tells that the unit is caring for nearly four thousand patients.

Staff surgeons remaining on duty at the Roosevelt Hospital are giving instructions in surgical technic and fracture work to army surgeons, and the head nurses, under the supervision of the directress of the training school, are giving an intensive training to Red Cross classes of nurses' aids who are being prepared to supplement later the regular nurses in the army hospitals here and abroad.

Many of the buildings of the Roosevelt Hospital are old, but have been kept in splendid condition. A more modern surgical pavilion is planned and is only awaiting normal, after-the-war conditions to spring up in place of the old one.

The operating service of the hospital is closed to all but the regular staff, but a small courtesy operating room is maintained in the private pavilion for accredited visiting surgeons whose patients are in the private rooms of this department. There are solariums for both men and women in the private wing, each equipped with its own dressing rooms.

The radiographic department of the hospital has the last word in motor mechanics, switchboard, lead protection and the most accurate mechanics for time exposure and for stereoscopic work. The assistant on duty in this department is an enthusiast.

The nurse's home in usual times has a capacity of 160 beds, and each nurse has a room to herself, but the larger war classes being taken in have made it necessary to crowd in many more than this number at present. Contrary to the usual custom of architects who plan nurses' homes, the architect of this building has provided wide, roomy closet space in the nurses' bedrooms; they have double doors and covered cupboards above them. Just off the large living room is a generous parlor. It overlooks some quaint old vine covered walls and a busy street corner.

The nurses' aids in training at Roosevelt Hospital have a special instructor. They are given 240 hours of class and demonstration. All of the young women taking this training have already had the usual courses given by the Red Cross, and the intensive training received here in addition will make them valuable assistants to the nursing forces now in service.

The Roosevelt Hospital is upholding in every way the dignity of its traditions and its reputation of loyalty to the government.

Indianapolis City Hospital, Indianapolis

The walls of the Indianapolis City Hospital building, known as the Burdell Memorial, are covered with remarkable frescoes. The visitor walks through halls adorned with painted figures, the size of life, of dryads and satyrs and dancing maidens, and heroes of the Greek myths, vivid impressions of green trees and still waters and blue skies.

In one children's ward the side walls show cats and dogs and barnyard fowls. In another there are portraits of children of different nationalities—a Scotch lassie and a little girl from Italy, a Slav boy and another from Japan, and so on down the walls above the long rows of white crib beds. The babies' ward has pictures of the children's old friends, the people in the fairy tales and nursery rhymes.

In one male ward great wall spaces are covered by pictures of the seasons, painted in the brilliant colors of spring, the soft greens and blues and maize colors of summer, the blazing red and yellow and brown of autumn, and the white and gray of winter.

One large ward on the top of the building, with large windows all around it open to the light, is known as the women's prison ward. The patients are all women from the jails and the streets. The walls here carry great painted spaces, reaching almost from the floor to the ceiling, of Christ in the manger, Christ in the carpenter shop, Christ in the streets of Jerusalem.

Several artists, foremost among them one of the colored race, from Indiana and other states gave their time and labor to the walls of the Indianapolis City Hospital, in the hope that they might help to bring a note of cheer and beauty into the lives of the city's poor who are cared for there.

The Methodist Hospital, Indianapolis

In the Methodist Hospital, Indianapolis, there are well ordered rows of convent beds. Walls of corridors and wards and service rooms have attractive colorings, and very evident effort has been made on the part of the management to avoid a cheerless hospital atmosphere. In the operating suite are very distinct units of service. Each operating room has its own anesthetic room, scrub-up room and supply cupboards. These cupboards open through the wall into both rooms that they serve, saving the running through doors and around corners to get needed supplies. The sterilizing rooms and all sterilizing apparatus and water heaters are on a balcony, with windows as well as outlets for escaping steam. This keeps the entire surgical suite free from condensing steam and the noise of open valves.

Of the twenty student nurses graduated in the last class from the hospital, seventeen have enrolled for active service in the Red Cross. The only reason that the other three did not volunteer was either that they could not pass the physical examination or that they were going to get married.

The hospital now has 250 beds and 165 nurses. They are taking in an extra war class of 30 in July and expect to have 200 nurses by the fall. This is surely doing their

best to meet the national need for nurses. The Methodist Hospital is certainly teaching and preaching patriotic duty and getting results to which it may point with pride in post-bellum days.

There are three salaried anesthetists employed; one of these is a woman. Senior student nurses are getting four months instruction in laboratory and radiographic work, and by taking some further post-graduate study may qualify to meet the present demand for laboratory and radiographic technicians.

The Children's Hospital, Philadelphia

To reach the Children's Hospital one has to go through the crowded colored quarters of the city, through narrow streets and past other streets that are so close together that it takes three of them to make a good city block. Rosewood street isn't quite six feet wide, but it is in the directory and just swarmed with houses and children.

The Children's Hospital is still in its first quarters, which, when the war is over and its new building plans are completed, will be used for dispensary purposes only.

A lovely blue painted and white-bound Bambino graced the front hallway. A white-capped and gowned nurse was carrying a very black pickanniny, and just in front of the information desk sat a tired and worried woman, a foreigner, with a sick white-faced baby in her arms, telling her story to the information clerk. In front of the switchboard a neat colored girl was answering the incoming calls.

The hospital is seriously handicapped at present because of its staff being reduced to a minimum on account of war needs. Very little surgery can be done at present. The few men remaining on the staff are working like heroes, but much of the work necessarily has to remain undone.

There are seventy-five beds in the hospital, and a large dispensary service is kept up by the institution.

The information clerk told me a funny story about a colored woman who works for them. Someone said to her, "Say, Mandy, is your husband in the next draft?" and she answered: "I don't know fo' shoah, Miss, but he's been a-limpin' lately most awful. I never done see so many men folks limpin' in ma life befo'. Since this new draft law come in everybody's a-buyin' canes."

Mercy Hospital, Philadelphia

The Mercy Hospital, which is an institution maintained for the care of colored patients in the negro quarters of Philadelphia, has been made from a row of quaint old brick houses with marble steps leading into them. Outside of the little office is a brick courtyard, with an old-time latched wooden gate in its wall.

The board of directors are planning to build a larger and better institution to carry on their work, and a campaign and benefit to raise funds is being undertaken at the present time.

The training school has been established since 1907, and since that has graduated fourteen nurses, who have gone out to do good work among their people in hospitals and homes for the aged and infirm.

An active woman's auxiliary is doing good work in securing donations of furnishings and food supplies for the hospital.

East Haven Hospital, Richmond, Ind.

At the East Haven Hospital (mental), Richmond, Indiana, it is a custom for either the superintendent or his assistant to see personally every day every patient in the institution and to shake hands with him. The resident staff believes that this personal contact is of immeasurable value in the care and treatment of the insane.



The
MODERN HOSPITAL

EDITORIAL AND PUBLICATION OFFICE.
58 East Washington Street, Chicago.

EDITORS.

Henry M. Hurd Fidelity Building, Baltimore
 Frederic A. Washburn Mass. General Hospital, Boston
 Winford H. Smith Johns Hopkins Hospital, Baltimore
 S. S. Goldwater Mt. Sinai Hospital, New York
 W. L. Babcock Grace Hospital, Detroit
 John A. Hornsby 58 East Washington Street, Chicago
 MANAGING EDITOR.
 M. K. Chapin 58 East Washington Street, Chicago

SUBSCRIPTION.

Domestic postage, \$3.00. Foreign postage, \$3.50 (15 Shillings). Single copies, 35 cents.
 Domestic rates include United States, Cuba, Mexico, Porto Rico, Canal Zone, Hawaii, and Philippines.

Contributors, subscribers, and readers will find important information on advertising page 42.

The Influenza Situation and the Hospitals

The current epidemic of so-called Spanish influenza has thrown a staggering burden on our hospitals. The situation would have been serious in normal times, but today the depletion of medical and nursing staffs by the demands of the army adds an element of strain which cannot be ignored. Situations of difficulty and stress, calling for clear heads and stout hearts, however, are just what hospitals, physicians, and nurses are trained to cope with; panic in their ranks need not be feared. Fortunately, there are signs that the high point of the epidemic has passed. Further suffering, sickness, and death there is bound to be, but determined action is backing up good counsel, and the thing most needed now is for every one to understand exactly what his part is in the battle against the common enemy.

What can the hospitals do? So far as devoted effort and sacrifice are concerned, most of them are doing all that is humanly possible, but suggestions as to improvement of method are doubly welcome now. Surgeon-General Rupert Blue of the U. S. Public Health Service has issued a personal and urgent appeal that nurses be released from private duty for influenza epidemic work, that all except urgent operations be postponed, and that volunteer nurses' aids be employed.

It is obvious, of course, that every nurse and every woman who is capable of nursing has a duty to perform in the present crisis; and the duty of everyone who can release a private nurse for epidemic service is no less obvious. Hospitals at present should firmly discourage that perfectly natural phase of human selfishness which consists in the desire to pamper one's own invalid to the neglect of others who may be suffering real danger.

Operations should be discouraged for two reasons; in the first place, the patient incurs an additional risk in undergoing anesthesia now when his system may be already undermined by infection; secondly, every operation increases the need for special nursing, since a private nurse is needed for at least forty-eight hours in each operation case.

That it is the duty of every hospital to employ and to train nurses' aids is the firm belief of J. O. Cobb, senior surgeon, U. S. Public Health Service, in charge of the division of Illinois and Indiana. One trained nurse on an eight-hour shift should, with ten aids under her, be able to care for sixty patients on a floor. Dr. Cobb has called on the public press to ask women to help in this emergency as a patriotic duty.

The nurses are thoroughly protected from all possible danger by gauze masks when on duty, and prophylactic doses of Rosenow vaccine. It may be added that arrangements are under way to produce a hundred thousand doses of the Rosenow vaccine daily.

It may be reassuring to know something about the way the U. S. Public Health Service is meeting the emergency, and Chicago, part of the division under Dr. Cobb's supervision, may be taken as an example.

The city has been mapped out in districts, and every nurse and doctor in each district is instructed to report any case of influenza under his or her care to district headquarters. Through cooperation of the Public Health Service, the local Red Cross, and the Visiting Nurse Association of Chicago, arrangements have been made to supply medical and nursing care wherever needed. A cheering feature of the situation, by the way, is the fidelity with which nurses on this service have adhered to their duty though tempted by offers of double salary if they would desert their posts to take private cases.

The epidemic is by no means over, but, by the means just mentioned, with the aid of the hospitals and physicians, and with public meeting places closed by local authorities, the end is believed to be in sight, and aid of some kind assured for all who need it.

The Training and the Rewards of the Woman Hospital Superintendent—Both Sides of the Question

Much is being said and written about the qualifications and special training of hospital superintendents. Except in large institutions, where medical men or business men of exceptional ability are in charge, receiving salaries of five to ten thousand a year for their work, most of these superintendents are women, graduate nurses. Many successful women superintendents had no opportunity, at the time they began their supervising careers, for any special preparation, and have trained themselves and created their own success. The time of the self-made executive has gone by, however, and today, quite rightly, the woman who wishes to become a hospital superintendent must fit herself for the position after she has graduated from a training school. If the hospital where she was trained is a small one, she must go to a larger institution for postgraduate work, where there is more clinical material to observe. She must have experience in minor supervising positions. She should have special postgraduate training in nursing education and hospital economics. She must be a member of national nurses' and hospital associations and attend their meetings, and she must keep herself informed on all literature concerning hospital betterment.

So much for what she must be and do to fit herself for the superintendency of a hospital. Now, on the other side, what is she going to get for all this preparation and what consideration will be shown to her in the position she will occupy?

There are many small hospitals which pay no more than seventy-five dollars per month and maintenance to a superintendent; many fifty-bed hospitals pay only a thousand a year and some are giving a salary of twelve hundred. The superintendents of these institutions sometimes have enough graduate assistants to help with the supervision. More often they do not. Frequently these women have to do the work of two or three, and, in the small towns where everybody knows the business of everybody else, they are severely criticized if any detail of the supervision is neglected. Very often such a superintendent has at best three assistants where she needs four, most frequently only two where she needs four, and in many cases only one. In several fifty-bed hospitals the superintendent has no graduate assistants at all. One successful hospital of sixty-bed capacity in the Middle West, owned and controlled by a group of doctors, specialists and capable men,

is doing the best work in that city. The superintendent is a capable woman, specially trained for hospital supervision, having had her graduate work in hospital economics and management in one of the large institutions superintended by an authority in hospital administration. The hospital mentioned was decidedly untidy, the nursing care of the patients without proper supervision, and the superintendent exhausted. She had a dietitian but no assistant or operating supervisor. The building was full of patients, and it was not humanly possible for any one woman to do the work in her own office, assist at operations, and be on the floors to supervise the nursing care; yet I have no doubt that she was being subjected to criticism for work left undone.

In another busy fifty-bed hospital, this extreme example was found: The superintendent was on the ragged edge of nerves. Her face was gray with fatigue. She had an operating supervisor, but this was the sum total of her force. There was no assistant, no dietitian, and not even a bookkeeper in the office. The superintendent did her own bookkeeping, tended the office phone, taught the nurses, planned the diets, and housekeeping, and did everything else. She was getting a thousand a year and was a promising candidate for admittance to a psychopathic ward.

In one thirty-bed hospital—and this is only one instance out of many such—the superintendent did everything there was to do, with one assistant who did not have enough fundamental education to teach a practical class or make out a week's bill for a patient. This superintendent was bookkeeper, office girl, dietitian, teacher, housekeeper, and buyer, did all the radiography for that county, cooked supper Wednesday evening when the cook was off, and sometimes fired the furnace on Sunday afternoon when the janitor was out. She was frequently criticized by the staff because she could not do the laboratory work and because she did not always attend every operation.

Do the people in the large hospitals ever realize what these women in the hospitals of the smaller cities and towns must endure, where there is no restraint in management or system to protect them as there is in the larger institutions? These women, no matter what ability or tact or personality they may possess, are open to discussion by the people of the town and must suffer many humiliations in silence. All the petty jealousies and personalities of the trustees and the staff, the nurses and patients become stumbling-blocks in the way of their work. In many places the superintendent must put up with an incompetent helper because the individual in question happens to be

a relative or a protégé of some board member or physician and acts as a go-between to report to the patron the superintendent's daily goings and comings. In some places she must buy the meat this month from John Smith, a local magnate who gave one hundred dollars to the building fund, her drugs from James Brown, a grafting retailer who happens to be the brother-in-law of the treasurer of the board, and send the dead to Joseph Jones, the undertaker, whose wife is the president of the Ladies' Aid.

She probably has to buy the stock food supplies locally and pay from five to fifteen percent more for them than she would have to if she were free to buy where she could do best for the hospital. She sometimes has to submit everything she plans to do to a committee of women who know nothing of hospital management and who treat her at times with less consideration than a foreman would treat a factory hand. And this woman in the small-town hospital must not resent anything, because the town is a little world in itself and Dr. Brown and Mrs. Jones, who wouldn't count for anything either socially or financially in a big place, are powers in the little one.

There are two sides to every question. While we are insisting on the proper training and preparation of these small-hospital superintendents, let us insist too that they shall be paid better, given enough assistance, and treated with the consideration due to professional women in positions of responsibility.

The Commercial Exhibit at the Atlantic City Meeting

All of the delegates in attendance at the Twentieth Annual Convention of the American Hospital Association recently held in Atlantic City who took time to study the commercial exhibit with any degree of thoroughness will concede that it formed an exceedingly interesting and instructive part of the convention. Far from being a "side-show," it was an important integral part of the convention, without which the convention would have been greatly impoverished. Members who failed to visit the various exhibits and ply the exhibitors with questions missed a real opportunity to inform themselves of the most recent advances in hospital construction and equipment.

The importance of the commercial exhibit lies partly in the fact that it puts delegates in touch with the latest devices and methods which make for economy and efficiency. Suppose that your laundry equipment is out of date and that you are considering the installation of new, and perhaps additional, equipment. Or, suppose that

some friend has given your hospital money to purchase labor-saving devices for the kitchen. Where could you find a better place to give careful consideration to the question of the best type of equipment to be installed than at the commercial exhibit? Here you can see the product itself and can handle it and inspect it closely. If it is a mechanical device, you can examine its mechanism and have an actual demonstration of how it works instead of having to depend merely upon a written description, which is seldom wholly satisfactory. The exhibitors, moreover, are always glad to explain technical points that may be difficult to understand unaided. These exhibits enable you to make a comparison of products and to choose on the basis of merit.

Members of the association do not need to have their attention called to the fact that the commercial exhibit is one of the association's chief sources of income. From this standpoint, assuredly, the commercial exhibit is important and should have the interest and support of all the members of the association in attendance at the convention. The exhibit can continue as a source of income only if the members devote a reasonable amount of time to an examination of the various exhibits and give the exhibitors an opportunity to present the character and merits of their merchandise, irrespective of whether or not they happen to be in the market for the exhibitor's particular product.

If the commercial exhibit is to be regarded as an important, integral part of the annual convention of the association, every effort should be made to develop it and to make it as interesting and instructive as possible. The trustees of the association, through the committee on the commercial exhibit, should consider carefully what needs to be done in order to induce more manufacturers to exhibit on these occasions. Careful consideration should be given to the question of what conditions should prevail as to space for the exhibits and their location with reference to the main meeting-hall of the convention. In selecting the actual hotel at which conventions are to be held, consideration should be given to the desirability of the space available for the exhibit. The association itself may well consider how it can contribute to the attractiveness of the exhibit over and above the efforts of the individual exhibitors to make their own exhibits attractive.

A number of exhibitors and delegates of the recent convention expressed regret that certain specific periods were not set aside each day exclusively for the examination of the commercial exhibit. With the possible exception of one evening, delegates could use only the odds and ends

of their time between sessions to visit the exhibit unless they were willing to forego some of the sessions of the convention. To carry out this plan, it may be necessary to place definite limits upon the time which the various speakers may have, and to have the chairman of the various meetings see that these limits are strictly adhered to.

A Nation-Wide Survey of Nursing Resources

The American Red Cross, which is by army regulations the reserve for the Army Nurse Corps, has been asked by Surgeon-General Gorgas to conduct a nation-wide survey of nursing resources. It will be remembered that some time ago the War Department made a requisition for twenty-five thousand nurses for war service by January 1, 1919. This requisition is certain to be tremendously increased before the summer of 1919, if the war continues. Up to August 1, 1918, the Red Cross had assigned over thirteen thousand nurses to service. In order that a sufficient number of graduate nurses may be withdrawn for military service with the least possible detriment to the interests of the civil population, the Red Cross is now asked to conduct a survey to ascertain the number of graduate nurses, both registered and nonregistered, in the country; also the number of pupil nurses, ungraduated nurses (women who left training school before completing the course of training), trained attendants, practical nurses, midwives, and women who have taken Red Cross courses. The survey will also show any special qualifications possessed by nurses, as the ability to speak some other language than English.

In the "Handbook of Information," issued by the Red Cross on the subject of the survey, it is suggested that graduate nurses employed in homes to care for minor ailments or to look after the general comfort and convenience of the household might well be replaced by semi-trained nurses; that many ward duties in hospitals and much routine work in dispensaries could be performed by attendants; and that the clerical assistant in the superintendent's office of civil hospitals need not, at least in war times, be a trained nurse.

The work is to be conducted by the Red Cross through its nation-wide organization of chapters and branches. As a single form of questionnaire is to be used in all parts of the country at the same time, and as all questionnaires are to be forwarded immediately from the chapters to division headquarters and thence to national headquarters, national tabulation of all essential facts will be made possible.

Experience has proved that knowledge of our own resources is one of our most imperious needs. As mentioned in the handbook, "while the proposed survey is intended primarily to meet the existing emergency and the demands of the immediate future, it will also prove of inestimable value in the event of the war continuing for a period of years and in reconstruction work during and after the war, particularly if it is kept up to date by the addition of fresh information from time to time." We have as yet only begun to realize dimly the tremendous task of reconstruction and reorganization which awaits us even if the war should end soon. To meet the demands which will be made of it, the nursing profession, as well as the medical profession, must be more highly and more completely organized. The first step toward this organization is to obtain that knowledge of itself which this survey proposes to furnish. The task with which the Red Cross has been entrusted is indeed a momentous one, and the results will no doubt be commensurate with the aim.

Increased Supply of Surgical Needles Soon Available—Conservation Still Necessary

We are asked to give publicity to several important communications from the section of medical industry of the War Industries Board.

In the first place, Col. F. F. Simpson, chief of this section, has good news for surgeons in the fact that an increased supply of surgical needles will soon be available for civilian needs. He suggests that, in order that manufacturers may arrange to take care of civilian needs without prejudice to war contracts, orders for surgical needles should be placed through the accustomed sources of supply for delivery as early as practicable. The sizes and varieties of needles available are at present somewhat limited because the manufacture of needles in this country is still on a somewhat experimental basis. A chart showing the sizes and kinds of needles most readily obtainable at present is furnished by the section on medical industry.

Conservation is still most necessary, and the co-operation of hospitals is earnestly requested toward this end. They are asked to aid in relieving a very serious condition by expediting as much as possible the return of empty nitrous oxide and oxygen cylinders to the point of refill. Hospital staffs are requested to limit as far as possible the use of supplies such as drugs, cotton, gauze, adhesive plaster, suture materials, surgical instruments, gloves, and other rubber goods. Every doctor and dentist in the country, moreover, is

urgently requested to go carefully over his instruments and pick out every scrap of platinum, no matter how small and no matter in what condition, that is not absolutely essential to his work. There are two channels through which these bits of platinum may reach the government; they are the Red Cross and the banks under the supervision of the Federal Reserve Board. Properly accredited representatives of the Red Cross will soon make a canvass for the purpose of collecting platinum that anyone may desire to donate, and all are warned against giving scrap platinum to any collector who is not provided with proper authorization to represent the Red Cross. The banks mentioned above will pay current prices for platinum. The War Industries Board recognizes that platinum is required in certain necessary surgical and dental instruments, but hopes that all physicians and dentists will use substitutes wherever possible.

Social Service and the Influenza Epidemic

A communication received from Miss Mary Antoinette Cannon, Director of Social Service, University of Pennsylvania Hospital, is of so much interest that we print it entire:

The epidemic of influenza now in progress in this country has entirely changed for the present the course of hospital social work. Ordinary forms of social work are suspended in many hospitals, and only emergency work is done.

The Boston Social Service Department, in addition to work in the hospitals, has lent workers to the Boston Nursing Association and has organized medical social workers to assist the nurses in social problems, such as provision for neglected and orphaned children, and convalescent care of families and relief in the homes. The emergency health subcommittee of the State Committee of Public Safety has organized canteen service for food motor service and has inaugurated a campaign for recruiting helpers for nurses. The hospital social workers have submitted to this committee a plan for medical social service.

In New York, as elsewhere, the hospitals are suffering from lack of nurses. Bellevue Hospital, which has seven hundred cases of influenza and many sick nurses, is using its social workers in nursing in the wards. The social service department has secured the use of motors to take early convalescents home and is opening quarters for sixty convalescent children near the hospital, as well as accommodations for well children whose mothers are ill in hospitals.

Philadelphia has opened eight emergency hospitals to take the overflow from the regular hospitals. All of these emergency hospitals are filled, and more are being opened as fast as they can be manned. Hospital social workers are helping the nurses in some of the emergency hospitals and in many of the regular ones. Some of the workers have given their services to the Visiting Nurses Society. A Bureau of Influenza Information has been organized by the Council of National Defense to receive requests for nurses, doctors, hospital care, burial service, ambulances

and help of all kinds, and to distribute these requests to various centers where the city resources are being organized. This bureau is practically dependent on the services of hospital social workers, loaned by the departments of many hospitals. School teachers, also, and other professional women are helping in this work. Social agencies of the city are combining, each one doing some part of the work involved in fighting the epidemic and caring for its victims. Neighborhood service is being organized, and the people instructed in measures of protection of health and care of the sick at home.

Social service is becoming organized with definite professional standards and a definite field. The foregoing letter suggests how important it is destined to become in the near future.

Death of Mrs. Warner

As we go to press, we are informed by Dr. Bailey, assistant superintendent of Lakeside Hospital, of the death of Mrs. Warner, wife of Dr. Andrew R. Warner, superintendent of Lakeside Hospital and president of the American Hospital Association. Mrs. Warner died on October 25, of a very extensive pneumonia following an attack of influenza. We know that we are expressing the sentiments of the entire hospital profession in extending to Dr. Warner our sympathy in his bereavement.

THE LATCHSTRING OUT

Friends of THE MODERN HOSPITAL are especially invited to call at our offices when in town and to bring us any items of news in regard to their institutions or their communities.

DR. DONALD E. BAXTER, who, it will be remembered, resigned the posts of director of the New York Committee for the Prevention of Infantile Paralysis and Eastern editorial representative of THE MODERN HOSPITAL in order to assume the position of chief of the bureau of tuberculosis of the American Red Cross in France, passed through Chicago recently on his way to China, whither he goes to become superintendent and general manager of the China Medical Board of the Rockefeller Foundation.

Major Baxter says that French hospitals are well worth the study of American hospital administrators. We are rather accustomed to the fond belief that American hospitals are absolutely the last word; yet Major Baxter finds that the French are five or ten years ahead of us in many ways. Their nursing service is not equal to ours, because their nurses are not drawn from a class which is socially equal to that which supplies our nurses. The French, notwithstanding, get good results from their nursing service.

MR. FRANK E. CHAPMAN, superintendent of Mount Sinai Hospital, reports that his institution has leased an entire apartment building, consisting of eighteen suites for the purpose, primarily, of furnishing additional facilities for caring for nurses, thus permitting of a larger enrollment of nurses; and secondarily, to permit the increasing of hospital facilities by devoting the space now occupied

by nurses to hospital service. By this move, the capacity of the hospital will be increased about seventy-five beds.

In order to meet the need of the country for graduate nurses, says Mr. Chapman, the Cleveland League of Nursing Education in cooperation with Western Reserve University, organized a special summer preparatory course of ten weeks for students wishing to enter Cleveland schools of nursing. The Mayor's Advisory Committee of Cleveland, recognizing the value of such a course, appropriated the necessary funds as a war emergency. Applications were made through recognized schools of nursing of Cleveland or directly to the registrar of the course. The nursing section of the Women's Committee of the Council of National Defense also helped in recruiting. The hospitals of Cleveland cooperated to the extent of furnishing room, board and laundry for all those who were to enter Cleveland schools of nursing, otherwise students had to provide their own living expenses. All students paid for textbooks, laboratory fees, etc.

The course was open to college women and high school graduates. Despite the fact that very little time was given to publicity, 101 students signed up for the course, eighty-eight of whom reported on the day of registration. Of this number, seventy-six completed the ten weeks. Four of these students expect to enter an Army School of Nursing; the others are now completing their three years in several of the schools of Cleveland. The character of the work was similar to that given at Vassar College this summer, except that no nursing procedures were taught. It consisted of intense theoretical work in the sciences which form the foundation for nursing. The pupils who have taken this course will be able to advance more rapidly in their work in the hospitals and will be better able to meet any war emergency that may arise.

"We do not feel," adds Mr. Chapman, "that such a course may be held up as ideal, but this movement toward centralization of theoretical training for nurses is in line with the thought of the leading nursing minds in this country, and it is hoped that the success of this summer course will be such as to warrant the establishment of permanent courses of this character in connection with the leading universities throughout the country."

Warning to Hospitals

It has come to the knowledge of THE MODERN HOSPITAL that a certain photographer has recently presented himself at an eastern hospital, claiming to have been sent by this magazine to make photographs of the institution, and that after taking certain photographs he collected a considerable sum of money for prints which he agreed to furnish the hospital but which, after more than three months, he has failed to deliver. No such person has ever been employed by us, or in any way authorized to represent us. Anyone in our employ, who may be assigned to visit a hospital for any purpose is furnished with unquestionable credentials, which the hospital authorities have a right to demand, and no hospital is ever asked to pay for photographs which we may request the privilege of making.

On the magnificent estate of Sarisbury Court, near Southampton, there is being built the largest American military hospital in Great Britain, planned to accommodate nearly 3,000 wounded soldiers from the western front. The central building of the hospital will be the old manor house, erected as a private residence 35 years ago by a wealthy British land owner. Around this the American Red Cross is building nearly ten acres of frame hutments.

THE MEMOIRS OF A HEAD NURSE

VI. Told at the Coffee Party—The Head Nurse's Story, Showing That What We Sow We Reap in Plenty—Also That What We Admire at Twenty, We Can't Even See Fifteen Years Later

Every girl who has lived in hospitals and nurses' homes knows the coffee party as an institution. Repeated menus, quantity cooking, a continuous diet of canned goods, and meals that have to be always planned economically lose their flavor in time for hospital workers, and the girl student nurses and supervisors—and superintendents, too—have feasts in the privacy of their own rooms.

Coffee is always the *pièce de résistance*—real coffee, made with egg and plenty of ground coffee and boiling water, and with plenty of cream to put in it—real cream. The rest of the menu varies. Sometimes it is sandwiches, dill pickles, and cake or doughnuts, sometimes the contents of a box from home; and sometimes, when it can be arranged without creating too big a scandal, bacon and eggs is the main dish. Everybody wears "undress" uniform, usually a kimono. Comfort rules rather than ceremony. Everybody sits around on chairs, beds, floor, or anywhere else available in a small room. The cooking is done on a small alcohol stove or an electric grill—or both.

The party that begins this story consisted of the operating room supervisor, the supervisor on corridor E and the one on the third floor, the red-headed dietitian, a new post graduate (a guest for the first time) and was complete except for the head nurse, who was late in getting over from the hospital. Finally she came in, gray in the face with exhaustion, but cheery as ever. "I am so tired," she said, "I could die just to get a good rest, to know that no one would ever wake me in the morning again. Any man who wants a good cook, a good nurse, and a patient wife can have me for the asking."

"Cheer up, Bob," said the red-headed dietitian, "the worst is yet to come. When you get on the outside of two or three cups of coffee and some of this coffee cake from Meyer's bakery, you'll feel like another woman. What kept you so late?"

"Oh, nothing much," said the head nurse. "Mrs. Seymour, up in Ward 3, just had another pair of twins. She had the first pair last spring. She is a regular spring customer up in the obstetrical ward. You know the woman I mean—the one with short, bleached hair, untidy and unintelligent. She is always making excuses and never has any clean clothes for either herself or the baby. Besides her being one of these useless and naturally untidy women, they really haven't anything, you know. That's what she gets for marrying a handsome church tenor."

"A handsome church tenor!" shrieked three voices at once. "You don't mean that fat, greasy husband of hers that comes to see her? Tell us about it!"

"I certainly do; that fat, greasy husband, as you call him, was one of the handsomest men you ever saw fifteen years ago, the leader of the choir at Grace Episcopal Church, the richest congregation in the city. At that time he was engaged to Miss Grace Crewes. Her father was a pillar of the church then, and they had slathers of money. She fell for his solo singing, and he for her father's money. Not a very good combination, you'll admit. You can't keep house on tenor solos, and she had too much sense and character to want to be around

a would-be opera tenor for three hundred and sixty-five days a year after the veneer had worn off.

"I met them just after I had graduated. I came back into the hospital for a case, and Mr. Seymour was the case. Bad appendix or something, I've forgotten just what. Miss Crewes was terribly cut up over him at that time. Thought, of course, that he was crazy about her, but anyone could see that he never could be crazy about anyone but himself. You know the kind. Thought all he had to do was to go down to New York, and the director of the Metropolitan Opera House would beg him to sing the leading roles in grand opera. My patient's room was filled with so many flowers I almost grew to hate them. It was a whole morning's work to take care of them. And the girls and women in town who sent the flowers and jellies and custards and affectionate notes would make you ashamed of your sex.

"I had not been on the case very long before I could see that Seymour was playing someone else besides his fiancée. The other was a little bleached blonde tawdry thing, playing a small part in a stock theater company at the Grand. She had been taking lessons of him. I remember she always wore a big black picture hat with dirty yellow plumes on it when she came to see him. I worried the soul out of me, fearing that fine girl of his would come in some day and find him spooning with his chorus girl friend. They were not particularly careful whether people saw them or not, and I knew that, sooner or later, something was going to happen—and happen it did, sure enough.

"One day Miss Crewes, his fiancée, came in while the other one was there. She always walked softly, and she stood in the doorway some time before they saw her. The girl with him was perfectly brazen about it. She just tossed her head as she went out and said, 'He wouldn't want you at all if it weren't for your money. He told me so!' Miss Crewes just stood looking at him. She was as white as the white tiles in the operating room, but she was game. The real people with her breeding always are, you know. She came over to the bed.

"Is that true, Clarence?" she said. "Do you really care more for this girl than you do for me?"

"He was like a peevish child that had been caught stealing jam. 'For heaven's sake,' he said, 'don't make a scene. I have my career to think of. Of course, I knew that you and your father would help me to get the right start in New York. It's only natural for a fellow to get engaged to someone that can help him, isn't it? Of course I like Millie, and I'm not going to turn her down, either. For that matter, my voice will be recognized when I get to New York and I can take care of myself and her, too, if necessary.'

"I don't remember that she even answered him. She just turned and went out, and, of course, that was the last he ever saw of her or her father's money. I heard that she was sick after that and that her people sent her to travel. She was terribly hurt, and I suppose it took her some time to learn to be thankful it happened that way.

"He did go down to New York, but the managers on Broadway didn't run after him to sing leading roles. Nothing like that happened. His sisters, who were teaching school, went without things they needed to pay his bills while he walked up and down Broadway, twirling his moustache and his cane, talking about himself and hanging around the agents' offices until he found a forty-dollar-a-week job with a fly-by-night stock opera company.

"After a while his family got tired of sending the best part of their salaries in answer to urgent telegrams and special delivery letters. So he married his chorus girl and finally came down to a place in the chorus himself, and they shared their eighteen dollars a week when they worked, which was spasmodically.

"A few years ago they came back here, and he has done a little of everything—sold pianos and victrolas on the installment plan and collected ten-cent insurance premiums. I heard all about them from one of the school teacher sisters.

"Well, I started out to tell you about what happened today and ran off my text. You know that we have needed a new wing for the maternity and children's wards for some time, and the board of trustees have been trying to get the moneyed people of the town interested about it. You know the Mansfield's. They own the street-car company and the telephone company and most everything else around here. They came to the hospital today to look over the place with a view to giving a few hundred thousand for a new building. Mrs. John Mansfield—she was Miss Crewes in the early part of my story—and her husband were with the president of the board and the superintendent. As luck would have it, just as they came through the swinging doors into the maternity corridor, there sat Clarence Seymour on the anxious bench waiting to go in to see his wife. You know what a greasy, untidy-looking thing he always is—and he looked worse than usual today. He was half asleep. His mouth was open, and his hands folded over his fat stomach. Under one arm was a newspaper bundle with some half-washed nightgowns and baby clothes sticking out of it. He awoke with a start just as they came in front of him. Talk about retribution! Her eyes rested on him for a minute, as they would if they were taking in a piece of furniture or a detail of a room she was passing through, and then they passed beyond him as if they saw nothing, and the group went on through the corridor.

"Which all goes to show," said the head nurse, as she ended her story, "that what we admire at twenty, we can't even see fifteen years later in life. More coffee and a sandwich and another pickle, please."

Quick Action of Red Cross in Influenza Epidemic

Illustrating the rapidity of the Red Cross to act in time of emergency at home as well as on the battle field, is the following item:

Last Wednesday at four o'clock Everett Beckwith of Aurora, Illinois, Red Cross Field Director at Camp Grant, called up the Central Division of the Red Cross via long distance 'phone, requesting as many ambulances as could be spared to handle the Spanish influenza epidemic situation at the camp. Inside of an hour the Bureau of Military Affairs at Central Division had recruited for the purpose five ambulances, which, with their drivers, some belonging to the Red Cross Motor Corps in Chicago, others coming from various nearby points throughout the state, were speeding on their way to the scene of trouble.

Don't Forget to Save Those Fruit Pits and Nut Shells

It has been discovered that by putting fruit pits and nut shells through a certain process, carbon necessary in the manufacture of gas masks can be made. Remember that thousands of these gas masks must be sent to our men in the trenches and that every fruit pit and nut shell will help. Also remember that you will facilitate matters by drying the fruit pits.

PAPERS READ BEFORE THE AMERICAN HOSPITAL ASSOCIATION

Some of the Interesting and Important Articles Presented at the Twentieth Annual Convention

Canada's Rehabilitation and Reconstruction Work

BY T. B. KIDNER, Vocational secretary of the Invalided Soldiers' Commission of Canada*

I felt very much honored when your association asked me to take part in your program, but I must say that it seems to me you have heard quite enough on this side of that invisible international boundary line as to what your neighbors and cousins on the North have done in this connection. For a number of reasons the work which Canada has done has been very closely observed by our friends in the United States, many of whom it has been my duty and pleasure to welcome when visiting Canada for that purpose. I may further say that we consider it a great honor to Canada that some of the methods which we were able to work out up there are being adopted by the United States, now that the problem of rehabilitation of its own disabled men is before it.

Three years ago last summer our disabled men began to come home, and possibly I cannot do better than to outline briefly the several steps to provide for the manifold and complex needs of the disabled which were taken as the necessity for each appeared.

First of all, a commission was formed to provide convalescent hospitals, and very soon a string of these was established from the Atlantic to the Pacific. They were of various types; some were private dwellings which had been placed at the disposal of the Government by patriotic citizens, and some were buildings belonging to other branches of the Public Service, which were turned over for the use of the Hospitals Commission. These served for a time, but before long it became apparent that improvised and altered buildings would not suffice. As time went on, men were sent back from overseas much earlier in their hospital history, and hence it came about that the commission had to undertake the provision of hospitals with facilities for active treatment as well as for mere convalescent work. Special types of buildings were devised and erected at various points throughout the country. The buildings were of substantial type, but not permanent in their nature. They were, of course, built to meet the rigors of a Canadian winter and have served their purpose splendidly. In this connection, it may be of interest to note the opinion which I have heard expressed by a number of prominent medical men that possibly large city hospitals will, in the future, be planned more on a temporary basis. As one man put it: "I do not think, after our experience of these temporary hospitals both in Europe and in Canada, we shall be likely to put so much money into bricks and mortar as in the past. Many of our magnificent city hospitals in America have now, by the growth of the cities, become surrounded with manufacturing and other undesirable buildings. If buildings of a more temporary character had been devised, it might have been possible to scrap them after, say, fifteen years' service, and erect new buildings with more up-to-date facilities and a little further out from the heart of the city. The increased value of the original site would prob-

ably go a long way toward meeting the cost of a new building of a temporary or semi-permanent type."

The next step which had to be taken was to provide for the placement in civil employment of men who had been discharged, after their rehabilitation was completed. An excellent scheme of cooperation between the Federal government and the various provincial governments was established, and in each province an employment commission, each of which has done excellent service ever since, was appointed.

The next step undertaken was the provision of vocational reeducation, and in this we were entering an almost unknown field. Outside of a little information as to what France was doing and a few reports from Germany, there was practically nothing upon which to base any scheme. A survey was therefore made of our returned men, and several very interesting facts were revealed. First, we learned that the number of men who were so seriously disabled as to be unable to return to their former occupations was comparatively small. Of course, only the more seriously disabled are returned to Canada, but of these it appeared that only about ten per cent would require training for new occupations because of their disabilities incurred in service. Up to the present, in Canada, this percentage has been slightly exceeded, but possibly this is due to the fact that the commission has always interpreted the regulations in favor of a disabled man if any doubt existed as to his eligibility for reeducation.

Another interesting fact which appeared was that comparatively few men had suffered the loss of an arm or a leg. Up to the end of April, 1918, out of about twenty-eight thousand invalids returned to Canada, only about fourteen hundred had suffered a major amputation. Also, remarkably few men are blinded. An official statement from Ottawa made only about one month ago gave the number of blinded Canadian soldiers to date as forty-six.

At the time the Hospitals Commission (now the Invalided Soldiers' Commission) began its vocational reeducation work early in 1916, there were about one thousand men under treatment in convalescent hospitals in Canada; and it therefore appeared that the problem of reeducating those men who were so seriously disabled that they could not return to their former occupations was not a serious one in point of numbers, considerably less than one hundred men apparently being likely to need it. There did seem to be a need, however, for some training for all the men, and the commission decided to provide opportunities for all men undergoing convalescent treatment to undertake some form of occupational work. It was pointed out that this would have a three-fold value: (1) In the opinion of many medical men (may I say today, ladies and gentlemen, all medical men), such work would have a distinct therapeutic value. (2) It would have a general disciplinary value in an institution, but it would also be valuable as self-discipline for the individual, and would prevent his hospitalization and consequent deterioration from an economic and moral standpoint (3) It was felt that, in many cases, training given a man during his period of convalescence might result in an improvement of his earning capacity upon his return to civil life.

Our beginnings were very modest. Usually, we fitted

*Mr. Kidner is now on duty in Washington with the Federal Board for Vocational Education, having been loaned to the United States Government by the Canadian authorities for a period of six months, to assist in the rehabilitation work for disabled American soldiers and sailors. The Federal Board for Vocational Education is the body charged under the Vocational Rehabilitation Act of June 27, 1918, with the provision of vocational re-education for disabled men after their discharge from military and naval service.

up some classrooms for general studies, a simple workshop of the arts and crafts type, and, wherever possible, we also introduced gardening and poultry work. This was gradually extended until, in connection with each convalescent hospital, a wide variety of opportunities were provided so that every disabled man, subject, of course, to medical supervision and direction, could undertake some form of activity, mental, physical, or both, which would be helpful to him. Among the many things which he have tried to do in Canada for our disabled men, I feel, personally, that this has not been the least important.

In the spring of 1917, thanks to the provision of some excellent hospital ships, our disabled men were brought home much earlier, and active treatment hospitals had to be provided. This involved the introduction of "ward occupations," as we term them, in which various forms of light hand-work, and sometimes general educational work, were provided for the men who were either confined to bed or unable to leave the ward. Today, although certain changes in the medical and military administration of the hospitals have been made, the three stages of the work of vocational rehabilitation are still carried on by the Invalided Soldiers' Commission, and may be stated as follows: (1) ward occupations, which are provided for men undergoing active treatment; (2) the curative workshops, wherein men in the convalescent stage engage in a variety of occupations; (3) the vocational or industrial reeducation for some new occupation, which is undertaken after a man has received his military discharge.

Time will not permit me to go into further details of the vocational work, as I wish to speak of some other steps which had to be undertaken as the needs developed. It is perhaps worth mentioning that, as far as possible, every kind of auxiliary treatment, such as mechanotherapy, hydrotherapy, and electrotherapy, was also provided. I want to mention in particular, however, the functional re-education, which is a very important division of the work.

As a layman, it seemed to me that one of the most interesting features of this work was the development of many simple devices for the individual man rather than the use of elaborate mechanical apparatus on which so much money has been expended during recent years by many hospital authorities. Of course, I do not pretend for one moment to speak with authority on this, for I have always been connected with vocational education, but it does seem to me that simple apparatus which can be made at the cost of a few cents for materials, and often made, if not by the sufferer himself, by one of his fellow-sufferers, will in nine cases out of ten be more effective than elaborate, costly mechanical apparatus, such, for instance, as the Zander machines.

The question of artificial limbs was another one which received the serious attention of the Hospitals Commission, which decided to establish its own limb factory and, as far as possible, to standardize the limbs. Fortunately, the proportion of leg amputations to arm amputations is about two to one. As many of you know, probably much better than I do, the question of a satisfactory artificial arm is most difficult one, and while the Government artificial limb factory in Toronto has produced some very valuable and useful attachments, I do not think that they would claim to have reached finality in the artificial arm. I do think, however, that the standard artificial leg now being provided for the Canadian soldiers will take a lot of beating.

Other matters have had to be taken up by the Canadian Government, such as the problem of land settlement.

A Soldier Settlement Board has been appointed, and a number of cases have been dealt with, although from the nature of the work it does not seem probable that many disabled men will be able to undertake agriculture as a livelihood, except in a few of its lighter forms, and to some extent in connection with the increasing use of farm machinery, tractors, etc.

I have not touched on the social side of the problem of reconstruction, but this has been well cared for in Canada. Indeed, every agency, public, semi-public and private, has cooperated in this great problem of the reabsorption of the disabled men into civil life. It is a big job and worth all the thought and all the heart that we can put into it. We must, however, preserve a just balance between sympathy and duty. We must not spoil our returned men by adulation and hero-worship. On the other hand, neither must we neglect any step which can assist in restoring the disabled man once more to usefulness, and, therefore, self-respect and happiness. By the passing of the Vocational Rehabilitation Act the United States has shown that it fully realizes that pensions and medals are not sufficient, but that it is the duty of the nation to aid those disabled in the nation's service to realize that the joy of life may still exist for them and that the greatest happiness comes from service—happiness for themselves and for the community.

The Management of the Dietary Department of the Hospital

By LULU G. GRAVES, President, American Dietetic Association, Editor Department of Dietetics, THE MODERN HOSPITAL

The noticeable feature of the dietary departments of many of our hospitals is their lack of management. Some sort of routine is necessarily established in the kitchen, and each individual fits his work into this routine in order to meet the requirement which is given great emphasis in every hospital, namely, serving meals on scheduled time. The importance of having prompt service of meals, both to patients and people who are well, is perfectly obvious, and no one would attempt to underestimate the necessity of it; however, the promptness should be invariable—morning, noon and night—day after day. This invariable promptness can be best assured only as a result of a carefully planned system of working, wherein each piece of work and each individual's part fits into the whole scheme in such a way that having everything done when it should be done is an inevitable result of the combined efforts of the whole department. Too often getting the meals out of the kitchen is the chief objective, an end to which everything else must be sacrificed; and usually much is sacrificed under such conditions. The time and efforts of the employees are not utilized to the best advantage and food is wasted in varying amounts, because the amounts to be served and the care of the food are secondary considerations.

The dietary department is the only department in the hospital which is concerned with every one in the organization. The nursing department and the physicians have to do with the patients, and their care; the office employees, with the details of business; the housekeeper has her force of cleaners, laundry workers, etc., to look after still other matters. But whatever their point of contact with the hospital, *every one in the organization eats*. I believe it is not too much to say that the reputation of a hospital depends as much upon its food service as it does upon any other service it renders. It is to be expected that people who are ill

do not have normal appetites, and attention should be given to the food of these patients as well as to those who are being treated by dietotherapy. If patients are pleased with their food, they are very apt to speak well of the hospital after they leave it, but if they are not satisfied with this service, they are sure to speak ill of it. It is too much to expect that nurses and doctors will speak well of their food—particularly after they have been at the hospital a year—but it is, nevertheless, essential that they should be adequately fed. Because their work is strenuous, they should have food that is nourishing and cooked in such a way that it is palatable and easy of digestion; because of their habits and environment, their menus should have variety and their service be as pleasing as possible. These things play a large part in the happiness as well as in the health of the nurse while she is in training. Much the same thing might be said of the food of employees as has been said of that of the nurses and interns, though the plan should be executed in a different way.

This department involves the expenditure of a large percentage of the money spent in hospitals. In business organization, the departments requiring the greatest expense are given the greatest attention and are put under systematic control. The contrary, however, is true in hospitals. The dietetics department of the hospital, which is of so much importance, is frequently given no attention by anyone with authority.

It is useless to take time here to discuss that which is so well known with reference to the undesirable location of many kitchens and storerooms and their inconvenient arrangement, as these are generally conditions that cannot be changed except by rebuilding or extensive remodeling. But the very fact that they can not be changed makes it all the more desirable that, in spite of these obstacles, intelligence and judgment be used in getting the best possible results.

One way of doing this is to organize the entire department under the supervision of one person. This concentrates the responsibility and forms a base upon which to build a compact and durable structure. With one person's interest extended equally to all parts of the system, they will all be developed and managed equally well.

Take, for example, the hospital having a steward or purchasing agent who buys the food materials and, nominally at least, has supervision of the main kitchen, the diet kitchen being in charge of the dietitian. The steward may buy very economically and judiciously; in some rare instances he may even give thought to variety in the menu; but how many of these men take any thought of this food material after it reaches the kitchen? He may be interested in having the meats served rare or well done—for, with all stewards, whether of hotels, clubs, or hospitals, meat is the chief consideration—but does he give any attention to the method of cooking, as to whether valuable food principles are retained or lost? Is there any difference in the method of cooking meat for use as meat, and that of cooking meat for the broth? Are the mineral salts in the vegetables dissolved into the water in which they are cooked and the water thrown away, or are vegetables cooked in such a way that the salts are utilized? Does he give any thought to the way in which food is sent out from the kitchen to be served in other parts of the house, and make provision for that which is not used to be kept clean and in good condition to be utilized later when it returns to the kitchen, if it does return? Does he

take into consideration the working conditions of the kitchen, keeping the utensils and equipment in good repair, and both the kitchen and storeroom clean and sanitary? Quite naturally, if no one else takes an interest in caring for these things, the kitchen employees will not do so. Doubtless we are all familiar with kitchens in which utensils are used which are not safe to use and in which one may find corners, plumbing atrocities, and other conditions which should not exist under any circumstances where food is being prepared, and which could not exist if the City Health Department were highly efficient.

In the opinion of the steward, these are minor details to which he gives no time; if one is fortunate enough to have a cook who will give attention to these things, the situation is much improved, but a cook who looks after details of cooking and cleaning has little time for anything else; consequently, some other feature is apt to be neglected.

With the steward in charge of the main kitchen and the dietitian in charge of the diet kitchen, we have two distinctly separate kingdoms, between which, all too frequently, there exists, if not a state of war, at least active hostilities, or at best only the observation of diplomatic relations. This means two sets of supply rooms or cupboards, two ice-boxes, and, to some extent, a duplication in cooking. This in itself is extravagant, for, naturally, the more scattered the base of supplies, the less the opportunity for conservation; and whenever this situation prevails, there is not the careful interchange of supplies between the two kitchens that there would be if both were under the same supervision. For instance, the main kitchen may have left in its supply enough meat, vegetables, fruit and dessert for two or three servings. As it is not enough to serve the patients of any ward, and is consequently of no use, it is either thrown away or eaten by kitchen employees who happen to be at hand—not as a part of their regular meal. We all know the frequency of such occurrences. Then why not have a system in which these small portions of food could be used in the diet kitchen for special diets or special orders, or served to some one whose appetite needs catering to in the form of a salad, a sandwich, a chowder, or a casserole? This not only saves small portions of food material, which in time aggregate large amounts, but it also teaches the nurse different methods of utilizing food in appetizing ways—a lesson which will be of great value to her when she begins private nursing.

Again there is the question of service. Generally, if the serving in the wards is supervised at all, it is done by a ward nurse or the dietitian. A nurse who will take an interest in saving food material in a hospital is so rare a specimen that she may be left out of the discussion. Yet, if the duty of conservation falls upon the dietitian, she has no authority to regulate methods of serving in the main kitchen. It is the custom of most cooks to send a certain definite amount of food to each ward, regardless of changes in diets or changes in number of patients in the ward. One remedy for this is to have a bulletin board conveniently placed in the kitchen, on which is written each evening the census of the several wards as given by the head nurse late in the afternoon. The cooks could go over this before beginning work for the following day and thereby judge of the amount of each kind of food needed. Ladles, spoons and dippers should be provided and the cooks taught to determine how many servings each will hold of soup, mashed vegetables, coarse vegetables, and other

things commonly served. In this way food can be apportioned to the wards fairly accurately.

Nurses, student dietitians, and every one connected with the serving should know how many servings can be cut from a pound of butter, or a loaf of bread, how many glasses of milk can be served from a quart and how many servings of sugar in a pound. The government is now giving this information in bulletin form.

Provision may be made for any who might wish a second serving, this allowance to be governed by the size of the ward and whether it is medical or surgical, male or female, and so on. Provision should also be made for the admission of one or two patients. If an unusually large number of new patients are admitted or discharged from any part of the house after the report is sent in, the nurse in charge should notify the kitchen in time to permit of necessary changes.

This may sound like a great deal of detail which is more trouble than it is worth. Not at all. Provided he has the utensils, it is much easier for a cook to serve systematically than in a haphazard manner; and it is much easier for the one doing the serving to know these details than it is for her to guess at them and have to handle the food a second time in order to correct mistakes.

In the larger hospitals with which I have been most familiar we have had made for our use food containers which met our needs very well. They are on the principle of a hot water bath, consisting of a large outside container into which fit smaller boxes or containers for meat, potatoes and other vegetables. Each ward has a container, the capacity of which corresponds to the size of the ward. They are made of heavy grade aluminum with a latticed rack or tray fitted into each of the large containers, forming a false bottom. Hot water is poured into this outside container, and the smaller receptacles containing the food are placed on the rack. A cover fits the larger or outside container. By this method the hot water prevents the food from becoming cold during transportation, and when it reaches the ward the container is placed over the gas flame, one flame being sufficient to keep the whole dinner warm. The water in the box prevents scorching or drying of the food, so that the last serving is as hot and in as good condition as the first, even in wards where forty trays are served. When the serving on the ward is finished the cover is placed on the container and the food returns to the kitchen in the separate receptacles in good condition and capable of being utilized again.

One person from the diet kitchen is responsible for the care of this food as it is brought back from the wards. This does away with the tendency to have several dishes containing the same kind of food accumulate in the ice-box if the supplies come back from different parts of the house at different times. With these supplies arranged in an orderly manner in the ice-box, it is a comparatively simple matter, in the morning, to see what is available, decide how it can be used to best advantage, and instruct the various people in the main kitchen and diet kitchen as to what they may have—also, it is valuable training for the nurse or student dietitian to allow her to look over the supplies and determine what she can use and for whom among her special menus each food is best adapted, and suggest ways of preparing each.

In addition, this system insures a minimum of waste either in the ward serving rooms or in the kitchen. However, in order to prevent waste or extravagance one thing is absolutely necessary—a proper interest in the work of the department. Without this, any system will fail to get the best results.

The nurses and others working in the diet kitchen should be given an insight into the work of the main kitchen and should be taught the principles of the things they cannot do in the diet kitchen. They should also be instructed in regard to steam cooking of vegetables and cereals, roasting of meat, uses of equipment, or labor-saving devices, as well as how to judge qualities, especially fish, poultry and meat. They should be told something of costs, and of the work and care necessary to the feeding of large numbers of people. This information will give them a different attitude toward the department, make them more careful when they do the serving on the wards, and less critical of their own food. A nurse who does not have a different viewpoint after such a diet kitchen training is an exception. The cooks should realize that the nurses are there to learn and that it is their privilege to help teach them. They will be interested in the dainty things sent out from the diet kitchen, and it is time well spent to tell them something of the diseases or the patients who are being treated by special diet. When they realize that an apparently small matter may cause serious results in diseases of metabolism they have greater respect for their work and take pride in doing it well. This spirit in the department is worth more than any other one thing, and it is one which is very difficult to obtain without an intelligent, tactful leadership.

This harmonious working together, as of one unit, should not be confined to the kitchens, however, but should be carried to every serving room in the house. Unless one has been brought face to face with it, one would scarcely believe that there could be so much extravagance due to seemingly insignificant things as may be found in the serving rooms of our hospitals. It is quite the customary thing for the nurse in charge of a ward to order a quart of milk, a dozen eggs, or a few oranges and lemons, more than she needs, in order to have them for emergencies. This may be permissible so long as she is thoroughly familiar with what she needs. Frequently, however, she is not familiar with them, and she thinks this is too small a matter on which to spend any time. Milk, the most generally used food material in the hospital, is in too many instances used with criminal extravagance. This is not intentional on the part of any one, but, since no one takes any special interest in the quantity used or in checking it up, the practice continues.

To one who has lived in a hospital and is accustomed to seeing everything in large quantities, these small amounts seem too trivial to require any attention; but when these small amounts are multiplied by eight or ten, or whatever number of service rooms the hospital contains, and then again by seven, the number of days in the week, the amount is no longer trivial. Very few of the people who are being served in our hospitals and other institutions with no care or effort on their part have any realization of the things to be considered or the real work required in the preparation and service of their meals. It is a trait of human nature to have no interest in a thing about which we have no knowledge, and this probably accounts for the indifference shown by so many even in positions of authority.

At this time, when it would seem that every one would feel a personal sense of responsibility, we find the service in many places changed only in so far as market conditions have compelled them to change, and any effort at conservation in the kitchen is met with much objection in the dining room.

On the other hand, the dietitian has an equally great

obligation to the other departments in the hospital. The nurses and physicians have their own troubles and should not have to contend with irregularities from the kitchen and storeroom. It is their due that they have supplies sufficient for their needs and that their supplies reach them in good condition; also that special orders and special diets receive special attention. Mention has been made before of the importance of good food and good service to both the sick and the well in the hospital.

There must be a desire for mutual helpfulness. It is small incentive to any department to develop a systematic or efficient method of procedure, only to have the results counteracted in some other part of the organization. Now, as never before, is there great need of close cooperation. So many of our nurses and physicians are giving their services elsewhere that those who remain in the hospital are called upon to do the work previously done by two or more people.

The dietitian has a great opportunity to enlarge her sphere of usefulness. She may assume greater responsibilities in the service on the wards, thereby relieving the nurse and physician of much of the care of the patients receiving dietetic treatment. She can extend this service to the dispensary patients as well as the ward patients.

But her difficulties due to market and labor conditions should be recognized and proper consideration shown her department. Special orders should be issued only when unavoidable, and care should be taken with supplies and extras of all kinds to prevent accidents or make it necessary to duplicate supplies or do extra work of any kind. While this other work cannot go on if details are neglected, it is perfectly obvious that the less time devoted to routine work, the more time will be left for the larger service.

This is where many hospitals make a mistake. They do not get the greatest possible value from their dietitian, because they have the wrong conception of her value. Dietotherapy has too prominent a place in the medical world today to permit of its being neglected. It is the dietitian's province to work with the physician in this branch of medical treatment, providing the proper foods and seeing that they are properly prepared and served, instructing the nurses in this subject in both theory and practice. And here again results depend upon cooperation; nurses cannot be given this instruction if their diet kitchen training is put in at any period in their hospital training, or if it is given for a certain length of time when they can most conveniently be spared from other parts of the house. A nurse cannot be taught dietetics as soon as she enters the school; neither can she be taught this subject in twelve lectures, or in four weeks' service in the diet kitchen early in her training. It is well for her to have some instruction early in her training which will fit her for the work required in the hospitals, but she has not the foundation, either in knowledge or experience in nursing, to understand the principles or the importance of dietetics until later in her course; and she should be given at least a part of this instruction with the more advanced work of the school.

You will note that a rather big piece of work has been outlined for the dietitian—supervision of the entire dietary department, including ward service; a more thorough course of instruction for nurses; and a very close contact with the medical men, not only with the patients in the hospital but also in the dispensary. This means she must be an executive, an instructor, and one of the hospital staff. Is any one else in the institution

given so many responsibilities of so diverse a nature, and still expected to give some attention to the details of the department? Of course, she cannot assume all of this without some assistance.

But, you will say, our dietitian is not doing this kind of work. She is not competent to do it (and I well know some dietitians do not care for this larger service). To both statements let me ask "why not?"

Are you making it worth while for a competent woman to take charge of your dietary department? How many of you are giving your dietitian any authority to develop her department or to carry out her plans? Or, are you giving her only the same authority and position that is given to a head nurse who has charge of but one ward and who is never called upon to do any teaching or other work outside of her individual ward, except perhaps in an emergency? This is very apt to be the status of the dietitian. She is asked to live in a room similar to that of the pupil nurse, with possibly another chair in her room or the privilege of an extra towel occasionally, but with no thought of comfort to counteract the influence of the noisy, hot place in which she must spend her working hours—a place in which you or the superintendent of the training school do not care to stay even long enough to discuss with her a question of interest to the department, preferring to call her to the comfortable office provided for you.

In spite of the fact that her work requires definite thought and planning, both for the department and for class work, the need for keeping records, accounts, per capita costs, etc., much communication with others throughout the house, and still others who are not in the house, either by personal interview or telephone, very few hospitals furnish their dietitians with office facilities.

Can you expect a woman who has fitted herself to do real dietetic work, or to become a good executive or to do both—to assume so great an obligation under such circumstances? She knows she cannot get the results she would wish, nor can she accomplish her best work in the face of such handicaps, and she has no desire to attempt it. A few hospitals have come to a realization of this and have given their dietitians a recognition which means more than anything else in the success of developing a well organized department; and there were a few women ready to do it.

If you are familiar with the achievements of women who are managing the lunch rooms and dining halls of some of our larger educational institutions and commercial plants you cannot fail to see how the same principle applies to hospitals.

These educational institutions feed only people who are well and have normal appetites, yet they have recognized the value of dietitians. How much greater should not the value of dietitian service be to hospitals! This field of opportunity has been opened so recently that it is not always possible for a hospital to find the woman they want at once, but there is almost always some one ready and anxious to do the kind of thing which is worth while. Frequently, however, it is more desirable that this type of woman be developed. The hospitals are helping very much in this respect when they offer a course of training to women who have had college courses in foods and nutrition. These courses vary in length from three to six months, and one hospital, at least, is known to offer a nine months' course, which is in the nature of post graduate work and has proved a good thing for all parties concerned.

It is worth a great deal to the hospital to have one with a thorough knowledge of domestic science to assist in the instruction and supervision of the work with the nurses in the diet kitchen, as well as in the preparation and serving of special diets. It makes possible the doing of more work and assures greater accuracy in all that is done. The dietitian is relieved of much detail if she has some one who can carry out orders intelligently and upon whom she can place greater responsibility than can be given to the nurse, whose time in the department is too short for her to get more than the general principles of dietetics. The experience is of great value to the one taking the training. It gives her an insight into hospital technique and affords her an opportunity to learn much of diet in disease that can be learned in no school or college. Later it is a benefit to the hospital employing the woman who has had this training.

It is to be regretted that there has been some objection to offering this training—both by hospitals, and dietitians. The objection of the dietitians has been that colleges send out graduates with such inadequate preparation that they are more of a hindrance than a help in the department. That is undoubtedly true in some, but not in all cases. When she finds she has accepted for this training a woman who is not fitted for hospital work, it is the dietitian's duty to the student, to the hospital and to herself not to allow her to finish the course. With so many desirable candidates as there are now, it is entirely unnecessary to consider one not adapted to this work; and there are so many fields of service that one should have no difficulty in finding a work for which she is adapted.

The objection of the hospitals to the student dietitian is that she may usurp some of the privileges of the nurse—that the pupil nurse is not permitted to do some of the things in her diet kitchen training she should do because these tasks are performed by the student dietitian instead. Such a situation need not and should not exist. The presence of the student dietitian ought to insure better and more complete instruction for the pupil nurse.

The student dietitian is usually a college graduate whose need is a training in application of her knowledge to diet in disease, and for administrative work, which she gets in her practice with the pupil nurse. The need of the pupil nurse is for the practical knowledge of food, its composition, preparation, and value in dietotherapy. The lines of training are so different for the two that there is little probability that one will detract from the other. In view of the value to be derived from such a course, it is to be desired that all hospitals having a well established medical and dietary department will formulate a course which would attract well-equipped graduates of domestic science.

Since the food situation has become so intense many hospitals which have given the matter no attention in the past are feeling the need of a trained woman in their kitchen. Let us hope that, out of the chaos and discouraging experiences of this critical time, a better and fuller relationship between the dietary department and other departments of the hospital is going to develop.

The American Red Cross is one opportunity which offers you many ways of "doing your bit." The best way to help your country is to give it part or all of your time and enthusiasm, but, if you can't do that, save every scrap of everything to be made over by the government.

Health Insurance and the Hospitals

By JOHN A. LAPP, Director of Investigations of the Ohio Health and Old Age Insurance Commission

What I have to say is not a statement of the known facts about health insurance nor an argument for its adoption as a social policy in this country. It is rather an attempt to describe the relation of the hospitals to such insurance if the same should be adopted by any state. We have been attempting in seven different states to determine whether state-wide compulsory health insurance should be favored for legislative action. These states are using for this purpose the time-honored method, a special commission of inquiry. Three state commissions reported in the last two years in favor of health insurance and one declared against it. No legislation has yet been enacted in this country upon the subject, but most searching inquiries into its merits by public and private bodies and by individuals are being made, and in one state, New York, a comprehensive bill has been introduced with the powerful backing of the State Federation of Labor. These facts bring the discussion of health insurance out of the realm of the academician into the realm of practical politics. It is time, therefore, for those directly interested to give it careful consideration.

While upon the general proposition I desire to express no opinion, I do wish to discuss certain aspects which have to do with the plans and specifications of the structure. We do not need to be reminded of the importance of the working drawing in mechanics, but it appears that in legislation everyone forgets that laws should be built upon working drawings of carefully prepared plans. We have too much "rule-of-thumb" legislation, too much "hand-me-down" thinking on law making. The contests of legislatures are pitched on the idea that somehow, some way, the legal structure will rise in true majesty without going to the trouble of working out the details and placing working drawings in the hands of the builders. It is not to be wondered at that there are some monstrosities, not strange that there are laws without roofs, chimneys, ventilation or light.

We propose to determine whether health insurance is desirable as a state policy, but in doing so we intend to have before us some tentative drawings of its scope and application. When we know what the plans contemplate we shall know better how to decide the main issue.

Let us see what social health insurance calls for as irreducible benefits. At the very lowest we have two which must be provided if the plan is to be anything more than a fifth wheel in our system of charity relief. They are cash benefits, and adequate medical and hospital care. Other benefits might be sacrificed. But if either of these is left out, the structure falls.

Speaking of compensation for accidents, the Washington Supreme Court recently said, "Compensation means more than the mere cash payment to an individual. Compensation to employees for injuries incurred by them may fairly be said to mean not only a money payment for the various elements of loss which may be the direct result of this injury. It includes, for example, the obligation to provide medical and surgical treatment, an obligation which does not necessarily involve payment in cash to the employee himself."

Insurance is a coverage of risk of loss, not money loss merely, but all loss. The loss to an individual by accident and disease consists of three parts—his wages, the cost of medical treatment, and the loss of working power. The relative importance of these depends upon the circumstances of the case, but in the majority of serious cases involving hospital treatment the loss of wages is the

minor item—that is, if the doctor and hospital bills are paid. But, aside from the relative magnitude of any one of these losses, there is such a direct connection between cash benefits and medical and hospital benefits as to make imperative, in any plan, ample provisions for both. Working men with families cannot very well take time to receive necessary medical treatment without cash benefits to tide them over, and the ambitious will not remain long enough under treatment to be permanently restored unless their families are sufficiently provided for support as a matter of right instead of charity. But mere cash benefits will not buy family support and medical care also. The primary object is to put the man back on his feet completely restored to working power as quickly as possible. He must have medical or surgical treatment. He cannot buy it with his cash benefits, which are needed for family support. If he goes without the necessary treatment, he remains on the insurance fund unduly long and perhaps becomes incurable or dies.

When workmen's compensation was introduced, only one form of benefit was prominently in the minds of lawmakers, the cash payment measured roughly by the loss. As an afterthought, some states gave a little medical care. A few states gave slightly more than a "little" care. Of the thirty-eight states and three territories which now have workmen's compensation laws, four states give no medical benefits whatever; nine states give medical care for fourteen days; three states give medical care for three weeks; six states give medical aid for four weeks or for thirty days; five states fix no time limit but fix a money limit. Connecticut, California, Idaho, Washington and Ohio give unlimited medical benefits, but in Ohio expenditures over \$200 must be approved in advance, and in Washington half is to be paid by the worker. Fifteen states which have a time limit have also a money limit, which ranges from \$25 to \$200.

The most liberal provision is that found in the United States Compensation Law, which provides for reasonable medical, surgical and hospital services and supplies, without limit as to time or amount, and, if necessary, transportation of injured employee to the place where he can be properly treated. Aside from those which grant no medical benefit at all, the most illiberal is that of Pennsylvania, which provides for reasonable surgical, medical and hospital expenses for fourteen days, but not to exceed \$25 unless a major surgical operation is necessary, when the amount is limited to \$75. Even a layman can smile broadly at that provision.

This review of experience under workmen's compensation acts is important in the consideration of medical and hospital benefits under health insurance. The same principles apply. The object under health insurance as well as under compensation insurance is to rehabilitate the man. We cannot do less in fairness to the disabled persons and to society. Unfortunately, in the past, man-power has not been properly appreciated. Human salvage has not been foremost. If men were thrown on the scrap heap, there were generally other men to take their places. The supply seemed inexhaustible. Humanity was playing the role of Rip Van Winkle. Now, however, things are changed. Man-power is important, and humanity is awake.

Whatever may have been in the minds of the advocates of compensation and health insurance in the past relating to rehabilitation must now be discarded in the light of economic and human facts. Workmen's compensation insurance must be directed to the prevention of accidents and the restoration of men physically and vocationally. We would be fatuous, indeed, not to heed the lesson and

make prevention and rehabilitation the cornerstone of the health insurance plan. We do not know in any state how many men have been deprived of earning capacity by accident. We do not know how many men who are now receiving compensation could be restored partially or completely to working power. And we know practically nothing at all about the extent of the problem of removing handicaps caused by sickness which impair working power. We are beginning to realize that we ought to know about these things under compensation. We shall probably not do much about the handicaps from sickness until the burden is definitely placed and a proper restoration plan has been worked out and applied.

The fact is that nearly everyone was thinking of cash benefits only when the workmen's compensation acts were passed. Medical and hospital care seems to have come merely by chance. Certainly the doctors and the hospitals were not on the job. Correction of the defect is proceeding, and we may expect many states to get the proper perspective at an early date. Already, Ohio has removed the \$200 limit fixed in 1913; California has removed her time limit; Washington, which at first gave no medical benefits, now gives unlimited benefits, though the worker must pay half of it—a quite indefensible provision from the standpoint of social insurance unless the worker is insured for his half of the expense. New laws generally are more liberal than the first ones passed.

It was natural that cash benefits should have overshadowed all else because everyone thought in terms of damage suits, which were always for a fixed sum in cash, supposed to cover all loss. The transition to the new era of insurance when the workers would be protected against all minor, as well as major, losses, and those losses were to be paid automatically without the aid of a legal bludgeon, was not fully comprehended, and the broad principles of rehabilitation were not applied.

It is important that, if we are to have health insurance on the same model, this mistake shall not be repeated. The restoration of the physical man to working power must be the primary object in this, as it should have been in the compensation acts. Cash benefits are merely the props of this process. If we are to restore a man we must keep him and his family from dependency. We do infinite harm at present by forcing a sick man to allow his family to eat the bitter bread of charity. It is not humiliating to most people to receive medical care from the public or charitable hospital, but to receive money from charity for things for his family to eat saps out all that is best in man.

So I say, cash benefits are necessary to the salvaging of sick and injured men to keep them from dependency, to enable them to stay long enough under medical treatment to effect a cure, and to give that contentment of mind which is necessary to recovery. The real object of it all is, however, the rehabilitation of the man in his working power so far as possible.

It is true that, in any case, a man might provide by saving for a rainy day, provided that rainy day did not develop into a rainy season. I shall not discuss that aspect of the case except to raise the question whether the average working man under present wages and costs of living can hope to provide for many rainy days, much less a rainy season, and further to suggest that the cold facts do not warrant any particular optimism in that respect, when in good times more than 10 per cent of the people are in economic distress, to say nothing of the fact that people generally are not at present prepared to withstand without distress an ordinary sickness of the breadwinner.

Coming now to the question of the relation of the hos-

pital to this whole matter: Clearly, the hospital must be the center of the rehabilitation movement. It has not been sufficiently so under workmen's compensation, partly because the hospitals did not see clearly the relationship between them and the new order, and partly because too many people thought in terms of charity. So it came about that hospitals were asked to perform their services at less than the actual cost to them. The hospitals were thus expected to bear part of the burden which, under the law, belonged to the employers. The reason for this, nobody ever explained. It just happened that way. Compensation commissions have been known to cut the bills of the hospitals arbitrarily without regard to hospital costs. They have been doing this by a process which has been aptly called a "pencilaninous process." Perhaps in some instances hospitals sought to make the employer or the insurance fund or company pay for a part of their own charity work by excessive claims. If so, it is no more defensible than that the hospitals should assume the burden of the employers or insurance company by furnishing services at less than cost. Regardless of the practice, the principle is clear, that under workmen's compensation and under health insurance the hospitals should receive enough to cover their total cost. They generally ask no more. They cannot be expected to accept less. They are unfair to a great purpose which they represent if they take less, for it is perfectly plain that the public, which contributes either by taxes, donations or benefactions, to the support of charitable institutions, either public or private, is entitled to see that the money which they spend is not used to assume the legitimate burdens of the insurance system, whether it be compensation insurance or health insurance.

Of the details of cost keeping and the division of the payments among doctors, nurses, and the hospitals, I desire to say nothing except to lay down the broad principle that no one should be expected to perform any service for the insured men without reasonable compensation. Let us once for all get it clear that, so far as the insured group is concerned, charity in the old sense of the term is no longer necessary.

The American Hospital Association has defined, for purposes of accounting, three classes of patients: free patients, part pay patients, and pay patients. The first are unable to pay for any part of their treatment and consequently the burden falls upon the hospital, to be paid out of public support or private benevolence. The "part pay patients" are able to pay a portion of the cost of treatment, and the balance is supplied by the hospital, as in the case of free patients. The "pay patients" pay at least the cost of their care, and from some a profit is obtained, which helps to supply the deficiency in the other classes.

Under health insurance a great part of the free patients, and most of the "part pay patients," become "full pay patients." The insurance fund will meet the bills for the cost of their care. The hospitals can still properly give charity to those not protected by insurance, and it can still sell its services to others at its own prices; but it cannot justly make the insurance fund pay a profit in order to take care of the poor, nor can it be permitted to accept less than cost and thus pass an illegitimate burden to the insured public.

It may be difficult for some who have grown up with the idea of hospital service for the poor to adjust their thinking to the new conditions. The humanitarian impulse will still find a field for action among the very poor who are below the insurance line. It will find expression also in enlarged service for those more fortunate ones who are to care for themselves under health insurance. In-

stead of furnishing the minimum which the poor require, it will seek to give the maximum which the medical benefits of insurance will buy. A great expansion of research will be possible. Scientific diagnosis, adequate clinical facilities, and precise record will enlarge our intelligence of disease prevention.

Accurate statistics of disease based upon complete diagnosis will lead us to the lair of many diseases. Statistics may sometimes be perverted, but, if we honestly follow where mortality and morbidity statistics lead, we shall find the culprit. With the unerring certainty of the blood hound following a scent, we shall be able to trace the courses and mediums of transmission of many dreaded diseases. We should develop more adequate statistical systems without health insurance, but they cannot in fact become precise without the aid of more comprehensive facilities of diagnosis and adequate provision for observation during care. When the aim is primarily to give emergency relief to the needy, this cannot be done. In such cases, hospitals and doctors can afford to give only the minimum required by humanity. Where it becomes worth while in dollars and cents to the community, the employees, and employers to give complete restorative treatment, the situation will be radically changed. We have a chance for the first time to put the vital statistician at work on a real job and to make his statistics work for the betterment of mankind.

If there should be a general development of social health insurance, we must expect to see a great enlargement of hospital facilities—and especially if we recognize, as we must, that it is good business to provide adequate medical and hospital care in order to keep people off the insurance fund and to restore them to work just as quickly as possible. The most progressive enterprises under compensation insurance recognized the business value of this idea almost at once, and there are hundreds of industrial physicians and surgeons whose job it is, principally, to prevent injuries from developing into partial or complete disablement and to bring the best care possible for the treatment of injured men, both for the sake of the man himself and for the cutting-down of insurance costs. Compensation commissions are recognizing the principle, and each year sees an expansion of the law and a liberalizing of its interpretation. The business and humanitarian principles so clearly developing out of the experience of the last ten years ought to be the foundation of any plan of social health insurance.

Lastly, there is the problem of malingering to be understood and dealt with by the hospitals and physicians. We know very little about malingering at present. The problem has been little studied in this country. While we have had many instances under personal accident and employers liability cases, it is only since workmen's compensation became general that the problem has become a social one. Health insurance will add another incentive to malingering, although it is generally conceded that there is far less of it proportionately growing out of disease than accident.

Malingering results from a desire to escape work, to excite sympathy or to reap pecuniary advantages. It should be carefully differentiated from disease due to mental or nervous derangement. It is the problem of hospitals and doctors to determine whether it is fraud or disease and to counteract the fraud and understand the character of the disease. The war is teaching many lessons. We are learning that much which might have been called malingering is not a conscious simulating of disablement. Sir John Collie, the leading English authority on the subject, recently said in the *Dublin Review*, "As it was known

that it was possible for a person to be really ill from merely witnessing an accident although no physical injury was sustained, and that a serious derangement of the nervous system, involving marked loss of function, could result from emotional causes alone, the soldier with no apparent wound or injury to show to justify his condition became the object of greater solicitude than otherwise might have been the case."

Malingering is not a new problem to be created by health insurance, but health insurance administration should profit by the experience concerning it. The extent of malingering is exaggerated for political effect. At the worst, only a fraction of one per cent are fraudulent malingerers. In two thousand cases of suspected malingerers sent for special examination in England Sir John Collie found 25 percent able to go to work, which would have been an insignificant percentage of all the injured workmen from whom the two thousand cases were selected. Yet the situation should be met by a new type of diagnosis. Even a slight amount of malingering has a bad effect upon the morale of the insured people, and is destructive to the few who fraudulently practice it. Hospitals have had much experience in the prevention of hospitalization among patients. That experience will be valuable in handling the same problem under health insurance.

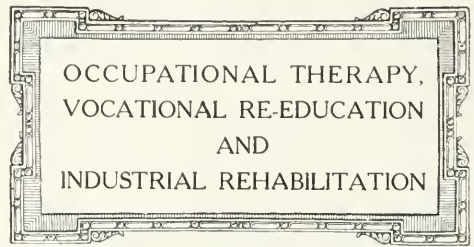
To sum up, this paper argues for adequate medical and hospital treatment for all cases under workmen's compensation and in any scheme of health insurance which may be set up; it emphasizes rehabilitation as the ultimate goal; it recognizes the strategic position of the hospitals in the administration of broadly conceived health insurance; it demands that all idea of charity shall be removed and that hospitals be neither required nor permitted to furnish service for less than its total cost; it urges an accurate system of records and statistics for tracing the incidence of disease and the fullest research and investigation of prevention and correction of disease; and it suggests a thorough study of the problem of malingering.

New Jersey Hospitals Organize

During the recent Atlantic City meeting of the American Hospital Association, representatives of New Jersey hospitals present formed a tentative organization. Mr. Cornelius S. Loder was elected chairman, Mr. Gallagher, superintendent Jersey City Hospital, chairman of the committee on constitution and by-laws, and Miss Eugenia D. Ayers, superintendent of Elizabeth General Hospital, chairman of the program committee. The association is to meet in November, in Trenton, for the purpose of perfecting an organization on the general plan of the national hospital association.

Influenza Causes Postponement of Convention of American Public Health Association

The influenza epidemic caused the postponement to December 9-12 of the annual meeting of the American Public Health Association, which was to have been held October 14-17. A good attendance was assured from the upper Mississippi Valley where influenza had not yet become generally epidemic. However, at the urgent request of the Surgeon General of the U. S. Public Health Service and of many Eastern speakers and delegates, the later date was set, it being judged unwise to take sanitarians from their posts at this time. Further announcement will be issued by the association at Boston, and will be published in the *American Journal of Public Health*.



Conducted by DOUGLAS C. McMURTRIE, Director Red Cross Institute for Crippled and Disabled Men and ELIZABETH G. UPHAM, Advisor in Occupational Therapy, Milwaukee-Downer College.

OCCUPATIONAL THERAPY IN CANADIAN WAR HOSPITALS

BY NORMAN L. BURNETTE, Inspector of Convalescent Schools, Invalided Soldiers' Commission, Canada.

Work, considered from the viewpoint of therapeutics and not vocation, is a comparatively new thing in the treatment of the Canadian wounded.

The reason is not far to seek. The immensity of Canada's war contribution and the obvious effect on her industrial life made it imperative that every possible worker



Fig. 1. A reconstruction aide giving instruction in weaving to a maimed soldier.

should be saved to the state in some shape or form. In the beginning, our anxiety to start the education or re-training of the returned men at the earliest possible moment blinded us to certain of the psychological factors in sickness. These factors are now so well understood that it is not necessary to go into them here. It is sufficient to state that men who have been exposed to the diverse influences of army life, followed by severe injuries and long periods of enforced idleness in hospitals, are neither physically nor mentally fit to stand the strain of industrial life, nor to take intensive training as a preliminary thereto. Both mind and body have to be brought back gradually to a state of normal activity. So, out of the result of our first experiment in vocational training, was born "occupational therapy."

Unlike the States, Canada had no trained workers and no experience covering a decade of work among the in-

sane. In one respect, this was an advantage. It forced us to approach a new problem with open minds uncolored by years of labor among asylum patients. It can not be stated too often or too emphatically that the returned soldier is neither a lunatic nor an old woman who wants to spend his declining years doing tatting or embroidering sofa cushions.

Having realized the part that occupational therapy had to play in the process of reconstruction, the first thing to



Fig. 2. Basket-making on the lawn.

do was to provide a corps of trained workers. The Department of Soldiers' Civil Re-Establishment decided on a central training school, and Toronto was chosen as the place of training. The great University of Toronto, which, in common with the other Canadian universities, had thrown itself whole-heartedly into all forms of war work, houses the school in one of the fine buildings of the department of engineering and applied science, and the school is governed by a committee drawn from the faculty of the same department.

Students are sent here from all over the Dominion and, before entering, sign a contract to serve for a full year after being accepted as "aides," in any part of the country, and in any type of hospital required. Before being taken on the establishment as an "aide," the student is required to do two months' probation work in a hospital. This is in addition to a period of part time practice work which the student gets in the Toronto hospitals during her university work. The Toronto hospitals are considered a training depot, through which all of the students will pass. The department pays a subsistence allowance of \$45 a month during training, and the probationers' training is very strict. The weeding-out process goes on all through the course without fear or favor.

Girls taken on the establishment are outfitted by the department with a uniform consisting of a green tunic and skirt with brown belt, and white veil, collar and cuffs. The summer hat is a white panama with broad green ribbon. The overcoat is a double-breasted military coat of dark green, with a belt and shoulder straps. The buttons on tunic and overcoat are khaki leather-covered. Probationers wear all white.

The school gives instruction in the crafts, and a staff of lecturers, which includes army doctors as well as other specialists, prepare the girls for a proper understanding of the varied problems which confront them.

Lectures by the matrons and officers commanding the Toronto hospitals are also given the girls in training, and the same valuable method of continuing their education is used when the "aides" go to an outside hospital.

It goes without saying that a high standard of entrance has to be maintained. The school could never undertake to turn beginners into skilled craftsmen in a short time.

Fortunately, some of the much-sneered-at fads and frills of our latter day education are coming home to roost, and a knowledge of design and one or more of the arts seems to be widespread.

Young as the work is, it is already an assured success. It has lighted up the sad, dark places in many a hospital and sanatorium. It has turned a home for incurables into a place of contentment, where one may hear laughter and witness the God-given miracle of pain forgotten through the joy of work. It has opened up a whole new vista of possibilities in the treatment of shock cases, and is vying with mechanotherapy in the bringing about of cures to crippled hands and stiff arms. Like many another war measure, it has come to stay, and it is to be hoped that what is being done in military hospitals will still be carried on in civil hospitals when this war is but a memory.

AN EXPERIMENTAL EMPLOYMENT BUREAU FOR CRIPPLES

Work Gives the Afflicted a New Lease on Life—Changed Attitude on the Part of Employers

By ELEANOR ADLER

Ten years ago a young cowboy came home from a Western ranch to spend Christmas with his family in New Jersey. When he started back for the West two weeks later, he saw his train just moving out, and, running for the steps, slipped, missed them, and fell under the wheels. Two days afterward he came back to consciousness in a hospital, to find both his legs gone at the knees. One careless moment had put him into the great army of the crippled.

The hospital did what it could before sending him back to his family with wooden legs and a pair of crutches. And there in a small room he sat for two idle and useless years—a brave but derelict boy. After a while his family proved too poor to support him and shifted him to a brother in Brooklyn. The brother in turn, tired of his care, gave him a small sum of money and told him "to get out on his own." But nobody would give work to a cripple. He lived in a furnished room, hunting daily for any kind of a job; then he drifted to a lodging house; and after despair and hunger had taken the fight out of him a policeman found him on the streets, arrested him as a vagrant, and sent him over to the Old Men's Home on Blackwell's Island.

And among the old men he might have stayed on for, perhaps, the rest of his life, sitting next to a cot reading a paper or staring at the wall—derelict indeed. But one day a happy chance sent two women on a visit through the ward, and they were so haunted afterward by the dreary monotony they had seen that they decided to start a course of basket-making for the inmates. When the teacher came she was horrified to find a bright boy of twenty-two among the old men. She got in touch, as soon as possible, with cripple agencies in New York—agencies which had long felt the need of giving crippled boys some kind of trade training, and had recently opened an experimental class in jewelry and metal work. The young cripple was taken off "the Island," lodged in a cheap boarding house and put in this class. Four months later he finished his training and secured a job. And from that day on he has earned his keep back in the ranks of normal human beings. He turns up once in a while to have "a leg repaired," but always says he can stump his two miles a day on his wooden feet as well as any. He is a thoroughly happy and contented man, one of the pioneers who has proved that a cripple can "come back,"

and that, with training and careful placement, the disabled man or woman can do away with disablement.

It may seem a far cry from the story of this cowboy to the needs of the crippled soldiers and sailors. But, at the time, the cripple boy blazed a trail in the United States. The contrast of what his life might have been, lingering on among the wrecks of old men, and what it became, back among the young and sanguine, was a dramatic revelation of wasted possibilities. It proved in a graphic way that a man who has lost his legs can be worth his salt industrially if he is given a chance to get some trade skill in a suitable trade. And it made it increasingly intolerable that other cripples should not have the same chance. The long lines of disabled men and women at the different agencies—all eager for work, any kind of it, and all hopeless of getting it—seemed more and more a tragical waste of good material. The problem, brought home in this way, finally became crystallized by many accounts of other cases; a movement was put on foot to provide such handicapped with adequate jobs, and, despite misgivings, a small experiment was started, an employment bureau for cripples.¹ At the time many doubted its practicability; cripples were still classed with dependents and beggars; and an appeal for funds, made to a roomful of men and women who had all been strong supporters of cripple work, met with refusal on the ground that the scheme was impossible. Nevertheless, the bureau was established, and succeeded in proving in a small way what it had hoped to prove, namely, that, with training and intelligent effort at placement, the large majority of cripples can support themselves.

Since the war has brought its quota of wounded, cripples have been pouring out of the hospitals abroad and in Canada, and this statement is being much more widely demonstrated, although, in these cases, it applies largely to the class of maimed and not of diseased cripples. Meanwhile, as employment bureaus for cripples are springing up in various cities in the United States, a study of this small experiment may prove helpful toward their work of refitting the disabled man, soldier and civilian. The widespread publicity of the new movement for war cripples is making familiar what two years ago seemed incredible, and it is hard to realize now that in May of 1916 the idea of getting cripples actual employment seemed to many people a visionary undertaking.

There had been one or two attempts before this to establish such an employment bureau, but they had not been permanent. The Charity Organization Society of New York ran an employment agency for the handicapped for five years, in connection with its general employment work. The society abandoned this work on the ground that there were increasingly few men applicants, and that it had become largely a domestic employment agency for women. Dr. Charles Jaeger conducted such a bureau in connection with his Hospital of Hope and Trade Training School for Cripples and gave it up when the hospital was discontinued. Dr. Richard Cabot and the Kings Chapel Committee had recently established an employment bureau for the handicapped in the Massachusetts General Hospital of Boston, but were intending to conduct it on a smaller and more intensive scale than seemed feasible in New York. So there was little precedent to look for at the start.

The radical difference between this bureau and its predecessors lay in its strict purpose to be a business enterprise and not a charity. The cripple and the em-

ployer were to be brought together, but the needs of the two were to be taken into equal consideration. Cripples who would not deliver a fair day's work would not be accepted as applicants, but referred to hospitals, old men's shops, or relief societies. The employer was to get a capable worker for the job he offered. It was keenly felt that any other policy would react—in fact, had reacted—on the cripple, so that his condition became in the end worse than before. The employer, who, having been touched on the score of charity to give a cripple work, found his business muddled, was increasingly hostile afterwards toward "crippled" labor. On the other hand, the applicants were not to feel that they were receiving charity, thereby frightening off the more self-respecting and better-class workers. As a result of this policy, the bureau was not conducted in connection with any hospital or charitable organization, but instead, as a department in a public employment bureau. It was not labeled a "Cripple Bureau." When an employer telephoned, he was told that a capable person would be sent him, and it was then mentioned that the applicant was lame, or a hunchback, etc. In this way attention was not focused on the handicap, and rejections on that account hardly ever occurred. The great advantage the bureau had in being a department of a public employment bureau, in addition to its psychological value with employers and applicants, lay in the State Clearing House for Employment Agencies. Calls from employers all over the city were registered every morning; vice versa, applicants were registered all over the city, and chances for work were thus greatly multiplied.

Neither New York city nor New York state has ever had a census of its cripples. The bureau was therefore entirely ignorant of the number it would have to draw upon. Estimates of various orthopedists differed widely, and, at the beginning, many people prophesied that there would not be enough cripples to keep the bureau in action. But the prophets came to no honor, and from the start, a steady procession of cripples of every kind, men, women, and children, marched or limped through the rooms. The records show that they came from every source—settlements, churches, charity organizations, cripple agencies, the municipal lodging house, the Red Cross, etc. A special point was made to become connected with the "cripple" classes in the public schools, and to put the children into trade training classes where they could work up to life-long positions in advantageous trades. Connection was also made with the disabled men and women who came from the Workmen's Compensation Bureau, and with the hospitals, although noticeably few applicants ever came from the last named quarter. Cripples were sent in from every part of the city, some from as far as Jamaica and Staten Island. A man who had only one leg, and who walked on crutches, had been told about the bureau by a policeman in Central Park.

The crippled man faces a much more serious situation than the woman. Any woman has ten chances for light and seated work to one for a man. He must either possess skill at a trade or the physical strength for heavy, unskilled work. The crippled man usually has neither. The fact, however, that men came to the bureau in much greater numbers than women showed that the problem was being reached at the right spot.

The task in placing cripples is not confined to securing immediate work. A very necessary branch consists of research work in regard to better industrial opportunities in general, new trades for which cripples can be trained, the working conditions and future possibilities of such trades. Opportunities are always coming

¹Under the control of the Federation of Associations for Cripples and the Hudson Guild.

up for better jobs and for new training classes. Such investigation opens many doors, bridges the gap between the bureau and employers, and makes a background for intelligent placement.

A third branch of a successful bureau consists in follow-up work with the individual person. Modern psychological methods lay great stress on the study of individual history and background before placement. Encouragement and follow-up work during the first month or two at a job are also practically indispensable. On the other hand, too much time may be wasted on investigation when a man needs a position. It is better to place fifty men fairly well than to make an exhaustive study of two or three and put them into superlatively suitable positions. The question is one of proportion and common sense, and suitable experience must hit upon a golden mean.

Though the cripple can become a normal industrial unit, he is always subnormal in some particular physical way. The work found for him must lie outside the zone of such subnormality, and this zone ought to be clearly defined by a doctor. In other words, the need of medical examination for each case is obvious. The bureau made connections with a clinic to which it was at liberty to send cases for examination and report, to learn exactly how many hours and what kind of work each cripple was capable of, and how much strain he could endure. Many men wanted to do work for which their strength was not adequate; others were found to be malingering, perhaps unconsciously. Unfortunately, the clinic proved to be too far away, and this opportunity was not utilized as much as would have been helpful.

The following stories will shed light on the more intimate nature of the problems that had to be met:

A middle-aged negro, who had lost his left leg, told the bureau that he had been out of work for the last ten years. He was refused wherever he applied. The bureau sent him to a firm, which paid him nine dollars a week to put tinsel on post cards at home, the prejudice against cripples keeping him out of the factory itself. After a year and a half of this work, he gave it up because the jobs were being turned over to girls at reduced wages. He was next sent to another company, which engaged him at ten dollars a week. But the old firm had discovered his value, and, not wishing to lose him, asked him to come back at higher wages and work in the factory, which he did. Half a year later he was promoted to foreman, and is still there. A good worker of that type never needs to be out of a job if only the proper agency takes an interest in him, finds him what he needs, and backs him up in getting it.

Another applicant was a boy of seventeen, who had become a hunchback in consequence of a fall. He was very short and deformed, but had a fine face. He said he was too old for school and that he was very unhappy there. Showing some beautiful lettering of his own, which he had brought with him, he begged for a job to do art work. He was placed with a jeweler, who undertook to teach him the trade.

A middle-aged man, whose leg was partly paralyzed, had been supporting himself by playing the piano at cabarets, but, as he said, "was not much at it." He was sent to a taxicab company, where he was given a clerical job at fourteen dollars a week, and was told that he could advance in time to bookkeeper work at thirty-five dollars. He has written recently that the firm says he has "made good."

One applicant had been an associate lawyer with the district attorney before both his hands were cut off in an accident. The doctor had managed to sew on the right

one with four fingers so that he could use it fairly well. He was at the time almost entirely without funds or prospects. The bureau placed him where he could do clerical work at \$12.50 per week, and he has been successfully employed at the same place ever since. He has notified the bureau that he will be glad to give talks for the Red Cross Institute and "cripple" work any time he may be needed.

Another applicant, who was deaf and had lost a finger through infection, had neither work nor home and had been sleeping on benches in the park. He said he had been a stage carpenter, but had longed for years to be a farmer in the country. He was placed in New Jersey, where he remained from April to September. Then, becoming dissatisfied with his treatment, he was sent to another position in the country as gardener. He has now been employed there for the past year, sending delighted letters about the work and his room, "which is so pretty that it ought to be occupied by a young girl, and not a homely old man like me."

A dwarf with a large head came to the bureau one day followed by a crowd of staring children. He said he had lost almost all hope of getting work, but came to try the bureau as a last chance. He was only seventeen years old, but looked to be forty. He was offered a well-paid position as dentist's assistant, but refused it because it meant running errands, and he had not the courage to go about the streets any longer to be stared at. Finally he was placed as an apprentice in a jewelry class, and at once turned out to have an unusual talent for artistic work. The teacher is delighted with his possibilities, and the boy writes grateful letters about "the last chance" that put him on his feet.

Another applicant was a very lovely girl of seventeen who had been run over by a car and limped badly. An unkind father at home threatened to put her out on the street. She was found to know typewriting, and was sent to a publisher who engaged her at twelve dollars a week. She has stayed on there, giving satisfaction ever since.

Another case was that of a Spanish girl of sixteen who had been born with only one arm. She had been studying portrait painting on a scholarship at the Academy of Design, but her brother enlisted and she found she had to support herself. She used an artificial arm and was very sensitive about the handicap. Before her application she had tried being a messenger, had been worked overtime, and had strange experiences taking messages to ships. The bureau got in touch with various real estate firms, and finally placed her as a telephone operator and cleaner at thirty dollars a month.

One day a very lame, exhausted Italian boy came limping into the bureau on two crutches. The day was snowy and slippery, and he had been directed to various wrong addresses. He explained that his family were very poor, that the father was out of work, that there were seven children, the last one only two weeks old, and that he wanted to leave school to help support them. He had a slight limp following an illness, and an operation six years before to help the lameness had greatly increased it. The bureau put him in a jewelry class, but found he could not attend on account of lack of car-fare. This amount was contributed, and work sent to the family. Later on, when the jewelry firms refused to employ him on account of his two crutches, he was put into a brace and then successfully placed at enameling. He now helps to support his family, and goes to school in the evenings.

At the end of a year of experiment, with October once

more on the horizon, the working thesis of the bureau seemed definitely proved. Though in a very small and inadequate way, it had demonstrated its theory. One hundred and sixty-eight crippled men and women had been given definite means of support. And what had been done in a small pioneer way might be done far more effectively on a larger scale. As jeweler, as machinist, as clerk, and as factory hand, the cripple had proved that he could earn a fair wage and be an asset in industry. In other words, he need no longer stand as a pariah outside the working world. He need not figure in the public mind as the beggar selling shoe-laces or asking for pennies on the street. Nor need he figure in the mind of the employer as an object of charity, given a job out of pity and counted zero as an industrial factor. Most important of all, he need not think of himself in any such roles. The work of the bureau has justified a new point of view toward the cripple in general. It proves him to be a man whom accident has handicapped in some particular manner and reduced to subnormal, but whom physical care, mechanical devices of some kind, industrial training and employment placement, all or one of these as he needs them, can return to the normal level, overcome his handicap, and send him once more marching in the industrial ranks. He can in the end keep step with the rest of the column. The war is going to help him enormously by making his handicap more generally understood and respected, by inventing new ways of minimizing his disablement, and doing away with the old prejudices against him. He has begun to show that he can "come back" commercially. The war cripples, by force of numbers and the attention such numbers focus, will widen the trail that has thus been blazed, and will sweep the cripples of industry along with them into their proper places. The new road will be one which every cripple can take toward a life of independence and congenial work.

VOCATIONAL INSTRUCTORS NEEDED IN MILITARY HOSPITALS

Immediate Need for Reconstruction Aides Presents Opportunity to Serve at Home or Abroad—Qualifications Necessary and Information Regarding Assignment

Within the next few months, approximately a thousand women will be needed in military hospitals at home or overseas to serve as reconstruction aides in the teaching of hand crafts and other subjects to disabled soldiers, and women interested in this particular branch of the service are requested to send applications at once to the office of the Surgeon General, attention Division of Physical Reconstruction.

The chief requisite for this type of service is unusual strength of character. Only those who feel themselves able to do hard and serious work, to spend long hours when occasion demands, to forego many of the luxuries and comforts of normal home life, properly to subordinate their personal interests to the good of the service, and to cooperate with medical officers, nurses, and others in the conduct of their work, should seek to become reconstruction aides.

The necessary qualifications for applicants are four-fold: age and civil status, personal, physical and educational.

In the first place, aides should be between twenty-five and forty years of age, but exceptions will be made in cases of unusual qualification. They must be citizens of the United States or one of the allied countries, and must furnish two references as to character and professional

ability. If married, they can be accepted only for work in this country.

Secondly, they must possess a knowledge of, and skill in, the particular occupations to be taught, attractive and forceful personality, teaching ability, sympathy, tact, judgment and industry. In overseas service, particularly, an aide will need to exhibit great ingenuity and cleverness in connection with her work in military hospitals.

Thirdly, applicants must pass a careful physical examination made by an army medical officer. They must be between 60 and 70 inches in height and between 100 and 196 pounds in weight.

And finally, all applicants should present the following educational qualifications: (1) at least a secondary school education, and preferably, college, normal or technical training; (2) capability of giving service in Class A and B, and ability to familiarize themselves with Class C. Class A includes social service, library service, industrial and fine arts, general science, English, commercial branches, free-hand drawing and design, mechanical drawing, telegraphy and signalling, French, manual training, agriculture, music, play and games, and mathematics. Class B includes knitting, weaving, clay and paper-machier modeling, wood-carving and toy-making, metal working, jewelry and engraving. Class C covers information in military procedure in hospitals, War Department's program for physical reconstruction of disabled soldiers, regulations as to insurance, pensions, etc., under War Risk Insurance Bureau, and opportunities offered by Federal Board for Vocational Training.

Aides will be divided into three classes: aides, head aides and supervisors. Head aides will be placed in charge of each ten aides assigned, and supervisors will be appointed in cases where there is need for extended supervision. Assignment will be made to any hospital in the United States, entirely at the discretion of the Surgeon General. Overseas service will be given only where desired.

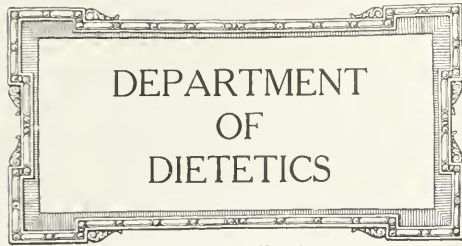
Home service will be compensated at the rate of \$50 per month and foreign service at \$60, with \$15 additional for head aides. Quarters and rations will be furnished and uniforms soiled on duty will be laundered. Where quarters and rations are not furnished, aides will receive additional pay at the rate of \$62.50 a month. Supervisors will receive \$1,800 a year, without subsistence. All aides will receive transportation to point of destination.

Appointments will be made for duration of war and for such further time as is deemed necessary, and the working day will be ordinarily eight hours, but may be longer if occasion demands. Annual leaves of absence with pay will be arranged where possible, and allowance will be made for personal illness not to exceed thirty days annually. Medical treatment will be furnished when serving under orders.

Aides will be placed under the control of the educational director, and in personal matters and quarters are subject to the same rules and regulations as nurses. For sufficient cause they may be dismissed from the service. Foreign service requires both hospital and street uniforms, but part of the overseas equipment will be supplied without cost by the Red Cross. Home service requires only hospital uniform, which may be purchased through the Red Cross for a sum well under \$50.

Individual correspondence is invited, addressed to the Surgeon General of the Army, Attention of Division of Physical Reconstruction, Washington, D. C.

A contingent of Japanese nurses has been sent to Vladivostok by the Japanese Chapter of the American Red Cross.



Conducted by LULU GRAVES.

Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, in care of The Modern Hospital, Garland Building, Chicago.

REPORT OF THE MEETING OF THE AMERICAN DIETETIC ASSOCIATION

First Annual Meeting Held at Atlantic City in Conjunction with That of American Hospital Association—Results Accomplished and List of Those Present

The American Dietetic Association held its first annual meeting at the Royal Palace Hotel at Atlantic City, September 26 to 28.

A preliminary business meeting was held Thursday at 11 a. m., and Thursday afternoon the following program was presented:

"Conservation in the Planning of Diets," by E. V. McCollum, School of Public Health and Hygiene, Johns Hopkins University.

"The Dietitian in Social Service," by Lucy H. Gillett, director Dietetic Bureau, League for Preventive Work, Boston. In the absence of Miss Gillett, this paper was read by Miss Blanche Joseph of Chicago.

"The Dietetic Needs of Today," by Martha Van Rensselaer, U. S. Food Administration, Washington, D. C.



MISS LENNA COOPER,
Vice-President American Dietetic Association.

At the regular business meeting Friday morning, Miss Smedley gave the report of the committee on resolutions, and a motion was made and carried to adopt such report as given. After a discussion on sectional work, it was decided to organize the sections as follows: dietotherapy, administrative, social service, and teaching. A motion was made and carried that the president appoint a member of the executive committee as chairman of each of these sections. In the very lively discussion of the training of the student dietitian, which followed immediately, the following points were brought out: nature of training, length of course, hospital facilities, conditions of living, etc. The report of the committee on revision of constitution and by-laws was given by Miss Cooper. A copy of the revised constitution follows. Since Miss Perry, the former corresponding secretary, left for overseas service, the work of both secretaries has been done by one person in an apparently satisfactory manner, and it was therefore recommended that only one secretary be elected. It was also recommended that dues be raised to two dollars per year. The recommendations of the committee were adopted.

The committee on nominations presented the following ballot, which was accepted by the association: president, Miss Lulu Graves, Home Economics Bldg., Cornell University, Ithaca, N. Y.; vice-presidents, Miss Lenna Cooper, Battle Creek, Mich., and Miss Violet Ryley, Montreal Canada; secretary, Miss E. M. Geraghty, New Haven Hospital, New Haven, Conn.; treasurer, Miss Emma Smedley, 1425 Bandywine Street, Philadelphia.

Friday afternoon the following program was given: "Conservation in Dietary Calculations," by Caroline Hunt, Home Economics, Department of Agriculture, Washington, D. C.

"The Dietitian in War Service with the Red Cross," by



MISS LULU GRAVES,
President American Dietetic Association.



MISS E. M. GERAGHTY,
Secretary American Dietetic Association.

Edna White, Head of Home Economics Department, Ohio State University.

In the absence of Miss White, this paper was read by Miss Emma Conley, and proved the occasion for a renewed discussion on the training of the student dietitian. The question of the intensive training courses for college women was brought up, and the general feeling seemed to be that it is better to give hospital training to women already graduated from reputable schools of home economics than to devote the energy to untrained women. The hope was expressed that the hospitals of the country would realize the necessity of opening their doors, as a patriotic duty, to student dietitians, provided that their dietary departments and the personnel of these departments are such as would permit offering favorable training for these women. Not only is this a patriotic service, but it is also a genuine war-time economy, as these students are capable of handling the food conservation problem in such a manner as to give the hospitals a value not measurable in dollars and cents; otherwise, they may be called upon to give up their present dietitians, for the government needs must be supplied. A motion was made and carried that the association send a representative to Washington to confer with the proper authorities in regard to the scope of training which hospitals should offer in order to render greatest value to the army, and Miss Lulu Graves was appointed to fulfill the commission.

The joint session of the American Hospital Association and the American Dietetic Association was held Friday evening, Miss Lenna Cooper of Battle Creek presiding. After the transaction of some business by the American Hospital Association, Mr. Henry C. Wright, secretary of the New York State Charities Aid Association, spoke on the work of the Institutional Food Conservation Committee, Mr. C. S. Pitcher, Kings Park State Hospital, read a paper on "Waste of Food in Hospitals," and Miss Lulu

Graves gave a paper on "The Management of the Dietary Department," which is published in this issue of THE MODERN HOSPITAL.

Saturday morning a meeting of the Executive Committee was held and the following appointments made: chairman program committee, Miss Lenna Cooper; chairman membership committee, Miss E. M. Geraghty; chairman section of dietotherapy, Miss Margaret Sawyer; chairman section of teaching, Miss Katherine Fisher; chairman section of administration, Miss Emma Smedley; chairman section of social service, Miss Blanche Joseph.

The time and place of the next meeting will be announced later.

When leaving, the greater number of members and delegates expressed the keenest appreciation of the value of the meeting and unbounded enthusiasm for the future of the association. The thanks of the organization are due Miss Graves for her splendid administration during the initial year. It is seldom that an association accomplishes as much in one year as this association has. Miss Graves has not only been a leader in the affairs of the body, but, through this medium, has also done much for the advancement of the profession.

E. M. GERAGHTY, SECRETARY.

* * * *

THE RED CROSS DIETITIAN SERVICE *

Its Work and Method of Providing Dietitians for Overseas Service, as Well as for Cantonments and Military Hospitals in the U. S.—Plans for the Future

By EMMA CONLEY, Chairman of Advisory Red Cross Dietitian Committee, States Relation Service, Department of Agriculture, Washington, D. C.

The Red Cross Dietitian Service was established by Miss Jane A. Delano early in 1917, before our entrance into the war, as a part of the Nursing Service of the Red Cross. Its purpose at that time was to provide

*Read before the First Annual Convention of the American Dietetic Association, Atlantic City, Sept. 26-28.



MISS EMMA SMEDLEY,
Treasurer American Dietetic Association.

trained hospital dietitians for the base hospital units then being organized by the Red Cross for overseas service and to furnish trained home economic teachers as instructors for classes of women who were studying home dietetics under the supervision of local Red Cross Chapters. This course was intended to supplement the course in elementary hygiene and first aid, and an elementary text book was compiled and distributed by the Red Cross.

It has been extended by the addition of three new outlines, War Diet in the Home, Emergency Cooking, and Course for Children, and about one thousand instructors have been registered as willing to undertake this teaching. When the United States entered the war, about twelve dietitians had been assigned to hospital units and during the summer the list of the fifty units was completed, one dietitian being assigned to each. Many of these units are now overseas.

Early in 1917 the enrollment of dietitians at the Red Cross Headquarters was about one hundred, nearly all of whom desired hospital service. Since then, the enrollment of teachers for the home dietetic course and those experienced in institutional work has increased to 1,630 at the present date, with about six hundred applications pending. About one thousand of these are instructors in the home Red Cross Chapter course, and over three hundred are dietitians in service in the army and navy cantonments and in overseas hospitals.

Since our entrance into the war, the Red Cross Dietitian Service has been extended to provide dietitians for additional base hospital units, for cantonment army and navy hospitals in the United States, and for military hospitals in this country. It has also been asked to provide dietitians for the thirty-five army schools of nursing.

In this matter the Red Cross Dietitian Service acts as a clearing house. The candidates register with the Red Cross Bureau, their fitness for service is investigated and certified to, and they are then recommended for service to the Surgeon General of the U. S. War Department. If they are accepted for army or navy hospital service, they become part of the military service of the United States and are transferred from cantonment to foreign service, or from one place to another in this country, at the discretion of the Surgeon General's office.

Dietitians requesting information about how they may serve are sent a circular of information and a set of application blanks. If they have had teaching experience they are listed as instructors. If their experience has been in hospitals, or other institutions (including cafeteria work), they are asked to send in a physical examination record, and are listed as eligible for military hospital appointment. The bureau then sends for the school and other credentials, and the endorsement of the Committee on Dietitians for the Red Cross is secured. A formal enrollment card is sent to those who meet the requirement of two years' of household economic training, or equivalent, and subsequent teaching or institutional experience. Those listed as instructors are also given an Instructor's Appointment card, and their names are sent to the Red Cross, Division Directors of Nursing Service, as are the names of those granted temporary authorization as instructors. These lists serve in advising chapters where to find instructors, and confirm any choice a chapter may make. Those who received only the enrollment card are told they will be notified of opportunities to serve under military direction or under the Red Cross organization abroad.

Applicants who do not fully meet the requirements are placed as reserves, and informed that their applications may be withdrawn for reconsideration after they have

completed further training or secured additional experience.

Our committee has found that several things seem advisable to insure good, well trained dietitians for war service and have them in readiness when the Surgeon General's office may call for them. There should be a list of the recognized schools for training dietitians so that qualifications may be more easily passed upon. The list of hospitals offering to take pupil dietitians should be extended, so that those who have had the required education may get the required experience under conditions similar to those which they will meet in war service, and courses should be started in our best equipped colleges and schools which will offer three or four months' intensive training to graduate dietitians who lack only the necessary practical training. This work is not within the province of the Red Cross Dietitian Service Committee, but some members of the committee, seeing the immediate needs, met with Miss Van Rennselaer of the U. S. Food Administration recently and outlined a course which was planned to insure the furnishing of well trained dietitians for war emergency service.

* * *

Requirements for and Outline of College Course for Dietitians

The following is the outline of the course referred to in Miss Conley's article, together with the requirements for admission:

REQUIREMENTS FOR APPLICANTS TO THE COURSE

Age.—Twenty-five, except in cases of younger women of exceptional experience.

Experience.—Practical knowledge of food and four months' experience in a hospital. This may follow the course.

Education.—

1. At least a two-year course in home economics, in advance of high school training, given by some institution of recognized standing, and proved executive ability preferably in food work, or—
2. A bachelor's degree from an institution of recognized standing and a strong foundation in science.
3. The proved equivalent of 1 or 2.

Personal Qualifications.—Vigorous health, strong moral character, proved executive ability, power of initiative and leadership.

References.—Three from faculty members of the institution from which the candidate was graduated.

One or two employers.

One from clergyman or prominent citizen. These references are not to be in the form of recommendations but names of persons to whom questions may be put concerning ability of applicant.

OUTLINE OF COURSE FOR TRAINING DIETITIANS FOR MILITARY HOSPITALS Section I. Institution Organization and Management.

Part A. Organization—

- Camp
- Hospital
- Auxiliary Organizations
 - a. Red Cross
 - b. Y. M. C. A.
 - c. Knights of Columbus canteens and cafeterias.

Part B. Military Rules and Regulations

- Camp and cantonment
- Hospital
- Canteen and cafeteria
- Miscellaneous.

Part C. Management

- Buying
 - Supplies—Equipment
 - Inspection—Marketing
 - Storage
- Accounting
- Bookkeeping
- Office filing
- Records and reports (keeping of)
- Inventorying
- Managerial

Responsibilities, direction of help, supervision, preparation and and service of food, menus and special diets.

Section II. French or Italian

Section III. Foods

Principles of cooking applied to

- a. Small quantities of food
- b. Large quantities of food

Section IV. Nutrition and Dietetics

Part A. Nutrition

- a. Food as a source of energy
- b. Food as a source of material for tissue
- c. Food as a source of regulating substance
- d. Various constituents of the diet

Meats

Cereals

Vegetables and fruit

Fats

Sweets

Part B. Dietetics

a. Menus

b. Diet in disease

Constipation

atony

spastic colon

Dysentery

Diabetes

Nephritis

Phthisis

Infections from intestine

rheumatism

neuritis—sciatica

c. Diet for infants and children

Supplementary for reconstruction workers

Section V. Science

Part A. Sanitation and hygiene

Part B. Pathological chemistry (clinical tests)

A course of study, which may be recommended for use in hospitals as a supplement to the technical training in colleges, is also being prepared. It will be submitted to the Army Nursing Department and the Surgeon-General as soon as it is completed. If it meets with approval, steps will be taken to have it adopted in all hospitals having facilities for offering student dietitian training.

* * * *

NEWS NOTES OF DIETITIANS

Miss Irene Enders, formerly dietitian at Greenwood Hospital, Greenwood, S. C., is now dietitian at Western Pennsylvania Hospital, Pittsburg, Pa.

Miss Elizabeth Given, who has been assistant dietitian with Mrs. O'Dea at Johns Hopkins Hospital, is studying at Columbia University this year. Her chief interest is the course in Nutrition offered by Teacher's College. Miss Jean Bradley will be Miss Given's successor at Johns Hopkins.

Miss Margaret Deaver, dietitian at Mt. Sinai Hospital, Cleveland, Ohio, has been ill for several weeks.

Miss May Miller of St. Luke's Hospital, Cleveland, Ohio, has been doing Y. M. C. A. work in Canada, having been granted leave of absence for this purpose.

Miss Lulu Graves will be in the home economics department of Cornell University the coming year, helping to establish the course of training for dietitians which is to be introduced this year.

Miss Violet Ryley, formerly of the Military Hospitals Commission of Canada, has been appointed chief dietitian of our camps and base hospitals. Miss Ryley's experience makes her well fitted to standardize the work of the dietitian in army service, and we are very glad to have this much needed work given into her hands. We do not know her official title, but understand that she has assumed her new duties.

Flavored Gelatine Food Products Recognized by United States Food Administration

Superintendents and dietitians who have had considerable difficulty during recent months in securing flavored gelatine products because of the restrictions which the

Sugar Division of the Food Administration placed on manufacturers of these preparations, will be relieved to know that the Food Administration has ruled that gelatine products for hospital use are essential. The earlier ruling, under the terms of which during the latter half of 1918 manufacturers were permitted to use only 50 percent of the amount of sugar that was actually used for the corresponding period of 1917, was modified in order to permit hospitals to serve this class of gelatine preparations to the sick and convalescent. In harmony with the desires of the Food Administration and the wise policy of the conservation of sugar wherever possible, it is anticipated that hospital officials will see that gelatine desserts containing sugar will not be served to any persons in the institution except patients.

ADVERTISING THE PUBLIC SANATORIUM

Minnesota Taking Progressive Steps in Publishing Essential Facts and Figures—Suggestions for Institutional Advertising Which Will Bring Desired Financial Results

By HERBERT F. GAMMONS, M.D., Superintendent, Deerwood Tuberculosis Sanatorium, Deerwood, Minn.

In order to get results with our public institutions we must follow the example of the owners of private sanatoriums by advertising to the public what we have to offer. The laity in general must be advised regarding the purpose and equipment of the institution, and they should not only be invited, but requested, to visit the institution in their locality.

Minnesota is taking the lead in building model sanatoriums for the tuberculous, which are run on a most efficient business basis and are under the supervision of well-trained administrators. A great amount of the credit for present conditions is due Dr. Robinson Bosworth and the Advisory Commission. In a great many instances the local sanatorium commission also is most enthusiastic and cooperates with the state authorities for the good of the sick. The burden of the local work falls upon the president of the sanatorium commission, who gives his time gratuitously and even goes to great personal expense because of his extreme interest in the project. I want to express my appreciation to the commission with which I am connected—and especially to the president, Dr. J. T. Thabes—for their interest in the institution and cooperation in its management.

The uninformed public has felt that a county institution would not be a fit place to send their relatives, that it was established for fundamental purposes of graft, or that it was run exclusively by some religious sect.

These ideas must be changed and the public must see things in the right light, so that the institution may be filled. One effective measure consists of picture post cards of the institution distributed to people of the surrounding community, inviting them to visit the institution, where they will be shown all points of interest, especially the method of handling the business end of the work, the menus and the preparation of food, and the accommodations for patients.

Properly written newspaper articles, repeated at intervals, and lectures before the chamber of commerce and all societies, not only on how to prevent and diagnose tuberculosis, but also about the institution, its origin, how much it is costing the community, and the good that it is doing—especially in certain extraordinary cases—will stimulate the public to sympathize with the project and insure the appropriation of the necessary amount of money for its maintenance.



Conducted by ANNIE W. GOODRICH, Dean Army School of Nursing and CAROLYN E. GRAY, Principal City Hospital School of Nursing, Blackwell's Island, New York.

Please address items of news and inquiries regarding Department of Nursing to CAROLYN E. GRAY, Principal City Hospital School of Nursing, Blackwell's Island, New York.

The Nursing Program of the Army*

By ANNIE W. GOODRICH, Dean, Army School of Nursing.

To say that this is a time for deeds and not for words is not only to utter a platitude; it is to state a hard, cold fact. To add that the success of the required deeds depends upon the effective cooperation of all the agencies involved, best obtained through a sympathetic understanding of the proposed program, is not only to utter a second fact, but to present the words which are an important part of the machinery necessary for the consummation of the required deeds; hence, our absence from an arduous post to outline in the fewest possible words the nursing program of the army.

THE PROBLEM

By July 1, 1919, five million men engaged in the most hazardous of occupations must be provided with a nursing staff sufficient to prohibit any loss of life or crippling of mind or body that can be prevented through nursing care. Simple to state—yet a demand never before made in the history of war or of nursing—a demand perhaps quite impossible to encompass, and one dependent not only upon the existing nurse power of the country expressed in numbers and efficiency, but also upon the provision of hospital beds and housing capacity for nurses overseas and on this side, and upon overseas transportation facilities.

Our province is limited to the question of the numbers and efficiency of the nurse power of the country to meet this demand. There is probably no one present who is not familiar with certain statistics relating to the nursing situation, namely, that there have been registered in the United States, since laws regulating the practice of nursing came into effect (the first in 1902), ninety-eight thousand nurses; that a reasonable subtraction for "dead wood" has been said by statisticians to be 10 percent, leaving eighty-six thousand nurses who should be available; that there are 1,575 accredited training schools, and that these schools graduated approximately fifteen thousand students in 1917; that the Surgeon-General is asking for twenty-five thousand graduate nurses by January 1, 1919, and a total force of fifty thousand nurses by July 1, 1919; and that this number has been deemed by some to be insufficient.

In view of the fact that the schools of nursing in this country have not yet celebrated their fiftieth anniversary, that there should already have been established the machinery through which such a demand could be efficiently met, is, despite any criticisms of failures to measure up immediately, a cause for congratulation.

The establishment of the Army Nurse Corps (female)

by an Act of Congress, 1897, and the later provision that the enrolled nurses in the American National Red Cross Nursing Service should constitute the reserve of the Army Nurse Corps, has provided the machinery through which the superintendent of the Army Nurse Corps, Miss Dora Thompson, presented on September 20, 1918, an enrollment of 17,197 graduate nurses. I think I am not mistaken in saying that this is the largest body of graduate nurses in any country or gathered together for any cause. She should be here herself to present in detail what may be well, I believe, defined as a stupendous achievement. The work of this enrollment proceeds rapidly, silently, and efficiently, and any study of the statistics shows that at no time has there not been a large number of nurses waiting transportation overseas, which must mean that any shortage at present existing on the other side, whatever may be the condition later, is not due yet to a failure of the Army Nurse Corps to provide a sufficient body of nurses.

It is of a moment's interest to review briefly the statistics relating to the Army Nurse Corps: On July 31, 1916, the report showed 162 enrolled nurses; in August, 1916, that number had risen to 332, about 50 percent of which were in the hospitals on the Mexican border. On August 31, 1917, the report showed that the total number of nurses enrolled was 1,631; approximately 331 were in the home service, 176 on the Mexican border, 476 with the British forces, 422 with the American Expeditionary Forces, and some two hundred and thirty awaiting transportation. The figures for 1918 read very differently: On August 16, the total enrollment was 14,315, and on September 13—a month later—it was 16,090. I have just given you the figures for September 20, which showed an enrollment of 17,197. Within the past few months the number awaiting transportation at the port of embarkation has rarely fallen below one thousand, and on September 20 was twelve hundred.

It is not unreasonable, we believe, to expect an enrollment of twenty-five thousand graduate nurses by January 1, 1919. But it is obvious that the enrollment of all the graduate nurses possible, draining all the resources of the country, will not provide the total number needed according to the program. It is because this has been realized that new machinery has been established, and I presume it is mainly this upon which you desire a report. Briefly defined, the purpose of the Army School of Nursing is for the immediate improvement of the nursing care of the sick in the military hospitals and for an adequate expansion of skilled nursing service.

While the establishment of a school of nursing is a new project from the standpoint of the army, it is by no means a new and untested method of caring for the sick. Had the problem of the sick and wounded, represented by five million men engaged in a hazardous occupation in a civil community been presented, we would have thought immediately in the terms of hospitals staffed by one-fourth graduate nurses as a maximum, and the remaining three-fourths student nurses. Rich indeed would we have felt ourselves with such a proportion! If we were thinking in these terms today, twenty-five thousand graduate nurses would mean seventy-five thousand students. And had we planned to carry on the school according to the methods which had already given the greatest return in efficiency, we would have made the high school requirements and included in our program affiliations for the services which could not be obtained

* Read before the Twentieth Annual Convention of the American Hospital Association, Atlantic City, Sept. 24-28, 1918.

through our hospitals. In establishing the Army School of Nursing, we have in no way deviated from the existing and accepted-as-best methods in the civil training schools, except that we have at no time conceived that our proportion of student nurses would bear the same relation to the graduate body that the proportion of student nurses in the civil hospitals bears to their graduate bodies.

Not until very recently, when Colonel Finney brought a message from the other side, did we conceive that the thought of those over there, without knowledge of our program here, was following exactly the same, or certainly very similar, lines as the thought of those studying the situation here. It is, I think, correct to state, following Colonel Finney's report, that a considerable body of the best experts in the subject are feeling that the work on the other side would be more efficiently carried on if the plan followed closely that of the civil hospitals. It is because of this fact that again the program of the Army School of Nursing has been expanded and, in addition to the enrollment of a student body of its own, is presenting to the civil hospitals the suggestion that they think in terms of affiliation for their pupils to obtain the experience in the military service. The details of this proposition we shall return to later.

For the moment, let us consider further the problem before us. The chronic and convalescent institutions in the civil communities have never been felt to be a good teaching field. The problem of the chronic and convalescent hospitals, with this body of five million men, again presents itself, and presents itself in more important terms than any previous problem of this nature. In thinking of a plan whereby we could cover this need, we conceived the thought that a group of persons not eligible as students might be used very effectively in this situation; hence the plan for hospital assistants.

We have, then, briefly summed up, before us this proposition: The largest possible group of graduate nurses; the largest possible group of student nurses, graded through affiliation with the civil hospitals (a body not less large than the graduate body, and, if it in any way approximates the situation in the civil community, at least 50 percent larger), for the acute service; and, for the convalescent and chronic service, a special group not to be known as, or meeting the qualifications for, student nurses.

SUPPLY

Considering the supply from the standpoint of the enrollment in the Army School of Nursing, the entrance qualifications for which are twenty-one to thirty-five years of age, and, educationally, the completion of four years of secondary work, we turn to the statistics presented by the United States Commissioner of Education relating to the number of girls in the secondary schools and in the colleges and universities of the country. We find that in 1915-16 the total number of girls enrolled in 12,003 high schools was 795,420, and of this number 119,660 were in the fourth year. In 2,118 private high schools the total number of girls was 79,249, and of this number 14,984 were in the fourth year, presenting the number graduated yearly from the high schools, as 134,644.

The tables relating to the number of undergraduates and graduate students in public and private universities, colleges and in technological schools in 1915-16 present 95,436 women.

It is not impossible to conceive that out of this num-

ber could be achieved an enrollment of fifteen thousand students, or even twenty thousand in the Army School of Nursing by June 30, 1919. We contend that it would certainly not be impossible to obtain if it were drafted. Not any more than it is conceived impossible to draft five million men, would it be impossible to draft thirty thousand to forty thousand students. We do not believe that this would be desirable, nor do we believe that this number will be necessary.

THE APPEAL

The appeal to the young women of the community is a very heavy one. They are anxious to give a definite service, and the great majority of letters which are received indicate an appreciation of the plan whereby their services are to be utilized. There is a group which has no conception of what trained service means, and which considers that the volunteering of a certain number of hours of work is a generous gift. I am glad to say that this attitude of mind represents only a small minority and that, in the main, we are enrolling young women who have been disciplined by years either in educational institutions or in the occupational and professional field. Every report that comes to us from the hospitals in which these students are now on duty (and there are now well over four hundred students) emphasizes the fact that we are dealing with an earnest and intelligent group of young women who are bound to "make good." From one base hospital now seriously stricken with influenza the report comes that all classes have been temporarily discontinued—as, of course, they should be—and that the students are giving full time on the wards and are of value.

STATISTICS

We believe that the statistics we have to present bear out our contention as to the possibility of enrolling the required student body. The school was approved on May 25, 1918; the first literature concerning it was issued on June 7, and the applications began to come in, in small numbers, early in July. The number being filed weekly has increased rapidly, until we now have received, according to the memorandum submitted to the Surgeon-General on September 21, 1918, 8,233. Of this number, 2,500 have been accepted—all high school graduates or an excellent equivalent, and many one or more years of advanced work. Two thousand and ninety-four have been rejected, and 3,639 are still under consideration.

Our aim was to place on duty by October 1 one thousand students. I do not believe that this number will be actually in the field on that date, but I believe that by the end of the first week in October the number will be fully realized; and I know that the lists of students to be called (a little beyond that number) will be in the hands of the commanding officers of hospitals almost, if not entirely, ready to receive them.*

Our further goal is to place five thousand students on duty by January 1. I dare to believe that, with two thousand five hundred accepted applications, this, too, may be realized.

RECRUITING AGENCIES

It would be, of course, impossible to conceive that this could be the case were it not for the recruiting machinery. We have—first and most importantly—the Division Directors of the Red Cross, who have from the very beginning of the establishment of the school directed stu-

*Owing to the influenza epidemic, some of these groups cannot be called immediately. Over one thousand students have been assigned and are awaiting calls.

dents to us. In addition to this, and to which we are indebted for the immediate and large increase in our enrollment, we have the United States Student Nurse Reserve "drive" carried on by the Woman's Committee of the Council of National Defense, with the assistance of the Red Cross and the approval of the Surgeon-General's Office. Here again we have an organization like the Red Cross, which has its divisions in every state and in many local communities. The recruiting, although the great "drive" has been closed, this organization proposes still to continue, as I understand it, as long as there is a need.

In addition to this, there has been recently made to the colleges of the country an appeal by the American Council on Education, with the approval of the Surgeon-General, to put in their curricula pre-nursing courses, and a definite quota of students is being called for—two thousand by October 1st, four thousand in the January classes, and five thousand in the spring. These courses are to be on the Vassar plan. The American Council of Education is using its machinery to help in the establishment of these courses and in the enrollment of students, and it is believed this will be one of the most important sources of supply, because of the type of women it will bring to us, and also because it will relieve us of much of the theoretical work of the preliminary four months' preparation and enable us to put these students for almost their entire time on the wards.

AFFILIATIONS.

One of the most important matters, from the standpoint of the Army School, is the suggested affiliation. It must be clearly understood that these affiliations are only desired if the hospitals see in them an opportunity to give their students a much desired experience—and, while giving them this experience, an opportunity of taking in more students, thereby making their schools take a part in both the military and civil service.

Briefly presented, the proposition is that the Army School of Nursing offers an experience in the military hospitals where training school units are established, to students in accredited schools of nursing who are twenty-one years of age and who have had not less than two years of secondary work. The arrangements will not differ materially from those made between affiliating schools of nursing. The course will extend over a period of not less than four months. The experience will supplement the experience in civil hospitals in medical and surgical nursing, communicable, mental and nervous diseases. The purpose of the course is to familiarize the students with the nursing system of the army.

Students who have completed the services not obtainable in the military hospitals, namely, obstetrics, pediatrics, and gynecology, can remain for a longer period if so desired by the parent hospital, and will therefore be eligible for service overseas. Students who are within four months of their graduation before entering the military hospital may be enrolled immediately upon the completion of that period, if their record is satisfactory, in the Army Nurse Corps, and will also then be immediately eligible for overseas service. Students who return to the civil hospital upon the completion of their four months' experience will have the advantage of being conversant with the military system and will also, therefore, upon graduation be ready for immediate service overseas.

Monthly Allowance.—The same allowance will be paid these students during the period of affiliation that is paid the students in the Army School, namely, \$15.00 a month.

Transportation.—It may be arranged that the Government can pay transportation expenses, certainly in the

case of students transferred from one base hospital to another or sent overseas. Students will be assigned to a military hospital in the locality of the civil hospital whenever possible.

Uniform.—The students will wear the nursing uniform of their own hospital. In case of their being sent overseas they will be equipped with the military uniform. Additional military uniforms beyond the first provided will be paid for out of their allowance.

Record of Work.—A record of the theoretical and practical work, together with an efficiency record, will be sent to their training school upon the completion of the course.

Diploma.—Students will receive the diplomas of their own schools.

The arrangements for the students of the hospitals which have sent base hospitals overseas, and which hospitals have recently received a letter from the Surgeon-General's Office, following Colonel Finney's report, differ slightly, and the following recommendations have been made:

That upon graduation of these students they will receive the diploma of their own school;

That the instruction they are to receive will be arranged by the superintendent of the training school with the chief nurse of the hospital unit;

That these students will be sent to their own base hospital overseas;

That only those senior students should be assigned who desire to remain in the service upon the completion of their course.

Intermediate Students.—One or two hospitals desire to send intermediate students, to be returned at the end of a year's service and to be replaced by others should their services still be needed. As this plan would enable these institutions to send a larger number of students, it is believed it would be desirable if it could be adopted, these students to receive the monthly allowance given to students in the Army School of Nursing, namely, \$15.00 a month, transportation expenses to be provided by the Government, the students to be permitted to wear the uniforms of their own schools, the military uniform and other equipment to be provided, and the selection of these students to be left to the authorities of the schools, with the requirement that they shall be twenty-one years of age and that they and their parents are willing that they should go.

Hospital Assistants.—At a recent meeting of a special committee to discuss the question of the part the civil hospitals are to take in the military situation, the committee approved of the general plan for affiliations as just presented, Dr. Goldwater not voting because representing at the meeting the Hospital Association and not being therefore in a position to express an opinion until the matter had been formally presented to this body.

At the meeting of this special committee, also, a resolution was presented by Dr. Goldwater and was unanimously passed, which reads as follows:

Resolved, That civil hospitals which have the necessary facilities be encouraged to arrange for the training and use of hospital assistants according to the plan and qualifications of the Army School of Nursing;

That such hospital assistants be enrolled through the American Red Cross, with the understanding that they will accept service as required whether in the hospitals in which they are trained, with the American Red Cross, or in the army hospitals.

The plan and qualifications as referred to in the motion provided that candidates for admission to the hospital assistants' service must be married women between the ages of twenty-one and forty, whose husbands are overseas, and who are free to give this service; also single women between the ages of thirty-five and forty-five. All candi-

dates must be in good physical condition and of good moral character. They must be graduates of high schools or present an acceptable equivalent.

We have not yet any important report to present concerning this group. We believe it to be a valuable one, and we are counting on a large enrollment. The Surgeon-General's Office has received over a thousand letters of inquiry, many of them from very desirable candidates. The hospitals to which these workers are to be assigned are not yet determined upon, but we believe they soon will be. They will be assigned to convalescent hospitals in this country where training school units are not to be established. Applications of candidates eligible for enrollment in schools of nursing will not be considered for this service.

We cannot close without a brief expression of appreciation for the contribution the civil hospitals have already made. There are many difficulties which have presented themselves in establishing the training school units in the various military hospitals, the chief of which was the obtaining of training school superintendents so thoroughly conversant with the problem that they could, with the least possible delay and under handicapping circumstances, accept and establish groups of students. Women upon whom the demands of the past year have been exceedingly heavy owing to the release of their graduate nurse body in large numbers, upon whom they depended for teaching and supervision, have foregone their vacations in some instances and, through the generosity of their boards, have been permitted to come into our service and establish this work. We have at every military hospital where a training school unit has been established, a director who is thoroughly conversant with training school work. In a majority of instances these directors act also in the capacity of chief nurse.

Miss Thompson has striven since the establishment of the school, when preparing chief nurses, to select those who have conducted schools and to place them in hospitals where training school units have been established, in order that they might master both problems at the same time. This has been of the greatest assistance to us, and will eventually make for the establishment in the military hospitals of a system strictly in accordance with the system in the civil training schools.

We are aware that several questions are arising in your minds concerning this proposed gigantic body of student

nurses. Suppose that they are obtained in the numbers desired, and that the war ceases next spring, what is to be done with the number over and above that required in the civil training schools and the small number that will be required after the war in the army? No more do we consider this an insuperable difficulty than Miss Clayton considered the question of affiliation an insuperable difficulty. When we turned to her at the committee meeting recently, as the person best fitted to speak on the subject, not only because she is the president of the National League of Nursing Education, but because she is the superintendent of one of the largest and perhaps most difficult schools in the United States, she replied simply that she saw no difficulties in it; we had all been thinking in terms of affiliation now for a number of years, and were used to considering such an arrangement.

Our answer concerning this large number of student nurses, it seems to me, is not much more difficult: The life of the military hospitals will be much longer than the period of the war. Probably a large proportion of these students will, upon the cessation of hostilities, drop back into their ordinary life and pursuits. There are fields of nursing in which we should have been glad to have placed student nurses long ago if a student body had been available. The public health field alone could care, we are sure, for a larger body of students than will be available, and will afford an experience that can well substitute for the experience in obstetrics and pediatrics, which, it is ordinarily conceived, we must obtain through the civil hospitals. My experience last year in Henry Street Settlement, with its great uncovered child sickness and the impossibility of providing a sufficient graduate and student nurse force for the obstetrical situation in an area limited by Fifth Avenue to the East River in one direction and Fifty-ninth to—I think—Seventy-ninth Street in the other, leads me to believe that nothing better could happen to the United States than to be compelled to provide the experience in obstetrics and pediatrics for a larger body of student nurses than has ever heretofore been conceived of. And I contend that this is not the statement of a visionary! There are other uncovered fields, the needs of which will not be diminished by the war, in which the student nurses can still render a service to their country until they have completed their course, and which will provide a valuable and interesting experience.

Army School of Nursing

In a letter to the editor, Mr. Pliny O. Clark, superintendent of the Ohio Valley General Hospital, says:

"I am enclosing some rather good prints of army school life, which I thought you might like to use. They

"We have at present sixty-two pupils, fifty more coming in the latter part of October, and more in December, until this base reaches its quota of one hundred and fifty pupils. I have been instructor of practical nursing since July, and am enjoying it very much; there are three others in-



Views of the Army School of Nursing, Camp Wadsworth, S. C., with a group of the pupils and a class in session.

came from Miss Nell Learned, who was formerly our night supervisor. She is now one of the instructors at the United States Army Base Hospital, Camp Wadsworth, S. C., and she writes in a recent letter:

structing in the different subjects, so, you see, we are kept busy."

The very interesting pictures of the school are shown herewith.



Conducted by BARROW B. LYONS
Superintendent Delaware Hospital, Wilmington, Del.

WORKMEN'S COMPENSATION, HEALTH INSURANCE AND HOSPITALS

A Farsighted Discussion of the Future Relation of Charitable Hospitals to Industry, Indicating Vast Changes Which the Future May Have in Store

By THOMAS HOWELL, Superintendent, New York Hospital.

Workmen's compensation has been in effect in New York for four years. At first, hospitals, owing to inadequate systems and a general lack of knowledge of the law, obtained little or no income for the treatment of compensation cases, but they are now handling this important work in a business-like manner and are obtaining encouraging results.

At the New York Hospital, which is located in an industrial district and therefore treats a large number of accident cases, we recognized early that the proper handling of this work would mean a substantial increase in our receipts, and soon after the law took effect we perfected a system which we have since employed. Our annual receipts at the Fifteenth-Sixteenth Street Hospital, exclusive of fees turned over to our attending surgeons, have been as follows: 1915, \$15,065.53; 1916, \$15,266.00; 1917, \$16,474.95.

Most of our compensation patients are of the ambulatory type. If we were to admit to the wards accident cases picked up by our ambulances we could probably double our present receipts. Most of the first treatment work is done by the admitting physicians, who are salaried men. The subsequent treatments are given by the out-patient surgeons, who receive small salaries. The majority of the New York hospitals charge in the case of ambulatory patients \$2 for the first treatment and \$1 for subsequent treatments. There is no established ward rate schedule. The ward rate is \$2.25 per day, the same as for other patients. In addition, we charge \$3 for each X-ray plate, \$5 for use of operating room, and \$5 for the anesthetic. Crutches and other appliances, and special nursing are also charged to the employer. We include in our bill the fee for the surgeon's services, which is turned over to the surgeon. Under the schedule in force at present, the largest fee allowed a surgeon is \$75, which includes first-aid, operation and additional subsequent treatment. Some of the New York hospitals retain all professional fees, but this is obviously unfair to the surgeons.

THE RELATION OF THE HOSPITAL TO THE EMPLOYER OF LABOR

The question is often asked whether, under the law, hospitals can compel employers to pay for surgical attention furnished their injured employees.

When the law first went into effect, the commission did not assume that it had anything to do with medical

bills except to pass upon their reasonableness. The Court of Appeals, however, sustained its power to make awards and to enforce payment of medical bills when the request is made by the employee, but the commission does not enforce payment of medical bills when the request is made by a hospital or a doctor; in other words, it deals exclusively with employer and employee, and does not recognize third parties.

However, the hospital may submit unpaid bills to the commission for an opinion as to their reasonableness, and, if the commission approves, the hospital is then in a position to take the matter into court. It is rarely necessary to take legal steps to collect bills after the commission has declared its approval, providing of course, that the case is covered by the law in other respects and the employer is financially responsible. We have experienced some difficulty in trying to collect in the case of small employers who are doing business with little or no capital.

If the employer, upon being requested to do so, refuses to furnish treatment, the employee is entitled to obtain such services at the employer's expense. Furthermore, by a recent amendment, if the employer, his superintendent, or his foreman, having knowledge of an injury sustained by an employee, fails to provide treatment, the injured employee may procure medical services without further notice to the employer, and at his expense. In every instance where it is possible, it is best to obtain the employer's written instructions to treat the employee, and charge the expense to him. When this written authorization has been obtained, there is rarely any difficulty in collecting.

The routine procedure at the New York Hospital in handling workmen's compensation cases is as follows:

1. When the patient applies at the emergency room for first-aid treatment, the clerk on duty enters his name, address, occupation, and name and address of employer, together with the diagnosis and date of treatment, in a book kept for this purpose. The patient is given a card which identifies him as a compensation case, and informs him when and where he is to return for subsequent treatments.

2. The next morning the compensation clerk sends to the employer a form letter, which gives the name of the patient, diagnosis and some information as to what the law requires of him. As the law requires that treatments by hospitals and doctors shall be authorized by the employer, these letters are of importance in a legal way. If the hospital can show that the employer acknowledged receipt of a letter, and gave instructions regarding billing, a legal claim for services can be easily established.

3. When the patient returns for subsequent treatments he is referred to the compensation clerk, who has on file a card, bearing the information obtained at the patient's first visit to the hospital. The date and nature of each treatment is entered on this card, as well as any other information regarding the patient that has any bearing on the matter. The clerk tries to get as much information as possible from the doctor regarding each case so that she is prepared to answer telephone inquiries at any time during the day and to make out the certificates required by the employee and the insurance companies at any time they are requested. All certificates are made out by this clerk and signed by her in the name of the superintendent of the hospital. This eliminates confusion in giving out information and saves the doctors a great deal of clerical work. When the treatment of a case is finished, the bill is promptly sent out.

HEALTH INSURANCE INEVITABLE

This country has successfully made the first step in social insurance—workmen's compensation. The next step is to provide health insurance.

Far-seeing employers have in many instances devised and adopted health insurance measures for their em-

ployees, but small employers have not been in position to do so. Compulsory health insurance, however, would provide for those of the smallest employer, as well as for those of the largest employer. It is estimated that from 70 to 80 per cent of those gainfully employed would be included in the benefits of this form of insurance. Statistics would appear to indicate that wage-earners, who will be the ones to benefit by health insurance, have higher morbidity and mortality rates than do the mercantile and professional classes. Accordingly, they are more in need of insurance than are those who are more fortunate.

Germany adopted health insurance in 1883. Since then it has been adopted by Austria, Hungary, Russia, Holland, Norway, Great Britain, and other countries.

Various organizations throughout the country are giving earnest consideration to health insurance, and the outlook for its being enacted into law seems excellent. The American Medical Association has taken up the question, and will undoubtedly be active in protecting the interests of physicians. The medical societies of Wisconsin and Pennsylvania have endorsed its principles. The American Academy of Medicine, the New York Chamber of Commerce, the American Public Health Association, the International Conference of Charities and Correction, the National Association of Industrial Accident Boards, and seven state legislatures have appointed committees to study and report upon health insurance. The Federal Commission on Industrial Relations and the International Association of Manufacturers are on record as favoring it. Contrary to what might be expected, however, there is some opposition to health insurance on the part of the labor unions.

The standard bill drafted by the American Association for Labor Legislation provides for a system of compulsory health insurance. It makes health insurance obligatory for all persons engaged in manual labor, and all other employed persons earning \$1200 a year or less. The self-employed, whose earnings do not exceed \$100 a month, may insure themselves voluntarily.

Every fund or society must provide for its insured members the following minimum benefits; medical, surgical, dental, and nursing attendance and treatment; medicines and medical and surgical supplies; sickness benefit equal to two-thirds of the weekly wage of the insured person; maternity and funeral benefits; also medical, surgical, and nursing attendance, and supplies for dependent members of insured's family. The funds or societies will be required to make arrangements for medical and surgical attendance by means of panels of physicians, to which all legally qualified physicians, hospitals and dispensaries shall have the right to belong, and from whom the patient shall have the right to choose.

HOW HEALTH INSURANCE MIGHT BE ADMINISTERED

The cost of the insurance will be assessed two-fifths to the employer, two-fifths to the employee, and one-fifth to the state. To the employer, this would mean about 1.5 per cent of his payroll; to the employee 1.5 per cent of his wages, and to the state 0.75 per cent of the payroll. Benefits would begin on the first day of illness, and continue, if necessary, through twenty-six weeks in any one year. Each panel would be administered by a board of directors elected jointly by employers and employees. In addition, there would be a committee in charge of the funds, and a medical committee elected by the attending staffs of local hospitals and panel physicians.

Health insurance will have a marked effect on hospitals and dispensaries. Under a system, such as is pro-

vided for in the standard bill, a large percentage of hospital and dispensary patients, workmen and their dependents, would automatically become pay patients. At the New York Hospital it was found that 79 per cent of ward patients and 95 per cent of dispensary patients would come under the provisions of the bill. As this hospital is located in an industrial district, the probabilities are that these percentages are somewhat higher than would obtain in hospitals generally. They are, however, very suggestive and would seem to indicate great changes in hospital relationships if the bill is enacted into law.

It is provided that the local fund authorities may make arrangements with existing hospitals to care for their patients, or that they may maintain hospitals of their own. The increased demand for hospital accommodations will result in the expansion of existing hospitals and the construction of new ones. It is to be hoped that the tendency will be largely toward the development of present institutions rather than the creation of new ones. In the past we have built more hospitals than we could adequately support; it is now coming to be generally recognized that the interests of the community are served better by a small number of well-supported hospitals, than by a large number of impoverished ones. It seems fairly safe to predict that the local fund authorities will not ordinarily care to assume the expense of erecting and maintaining hospitals, but will, for prudential reasons, depend on existing institutions.

The increased demand for hospital accommodations will be due largely to the fact that sick workmen will not delay so long before calling in a physician or applying to a hospital. It has been asserted that the average workman has not a single week's wages saved for the proverbial rainy day; consequently losing more than a few days' time is a serious matter for him. Frequently it means dependency for himself and family, and he does not as a rule surrender to sickness until he is actually compelled to do so. When he is furnished protection by means of health insurance, his condition will be different and he will not hesitate to go on the sick list, and demand early medical and hospital care. This is borne out by German statistics, which show that the morbidity rate has increased under health insurance. It is interesting to note that, while the morbidity rate has increased under health insurance, the mortality rate has decreased. This would appear to justify the assumption that the early treatment of disease reduces the death rate.

Again, it seems safe to assume that the authorities of the local funds will encourage their insured to apply early for treatment. They will try to conserve their funds by sending their insured to hospitals early while there is still hope for speedy restoration to health, instead of waiting until the disease has become chronic or incurable.

As hospitals will be paid for caring for health insurance patients, and as this class constitutes a large percentage of patients treated, health insurance should make their support much easier than at present. Hospitals which now treat largely free patients will be the most benefited by health insurance, and, conversely, those which treat largely pay patients will be the least benefited.

HEALTH INSURANCE WILL NOT INJURE PHYSICIANS

It is clearly the duty of hospital authorities to watch carefully all health insurance legislation introduced into the various legislatures and to insist that the interests of institutions shall be properly safeguarded. It is much more satisfactory to enact the right kind of a law in the

beginning than to depend on subsequent amendments. One of the great defects of the English law is that it makes no provision for hospital care. It provides only for such treatment as can be properly undertaken by the general practitioner. Accordingly, hospitals and specialists have no legal protection and are worse off than they were under the old conditions. The general practitioner takes care of the routine work and sends the difficult and obscure patients to hospitals; and although he is paid for his work, the hospitals receive little or nothing for theirs. We must avoid blunders of this kind.

Not only will the financial status of hospitals be changed, but the character of the work they are called upon to do will be different. The change will be particularly noticeable in out-patient departments. The insurance, or panel, physicians will take care of much of the work which now falls to dispensaries. They will treat such patients as are now ordinarily treated by general practitioners. When the case is one that requires special treatment or any attention which the panel physician is not qualified to furnish, the panel physician, the officers or directors of the funds are authorized to refer the patient to a specialist, or a diagnostic clinic, a hospital or a dispensary, as the nature of the case demands. In this way, difficult or obscure cases will come to the hospitals or dispensaries for consultant's opinion, for diagnosis, or for therapeutics.

The hospitals and dispensaries, being largely relieved of the care of routine cases, will be enabled to develop group medicine. The dispensaries will be given over largely to specialists and will develop into scientific diagnostic clinics. This will be a distinct improvement over present practice. It will accelerate the development of scientific medicine and will benefit the patient, who will be able to command the services of more skillful doctors.

The number of cases treated in the dispensaries will undoubtedly be greatly decreased. Even under the unsatisfactory English law, the decrease has been about 20 per cent. With fewer patients to care for, the doctors will be in position to devote more attention to each patient. As hospitals and dispensaries will be paid for their services, they will have to provide remuneration for their staffs, just as some now do in compensation cases. In the case of ward patients, this will be a simple matter. The hospital will be paid for the board and care of the patient and the medical fee will go to the physician. In the out-patient department, the division of the receipts will be a little more complex, but an equitable adjustment should not be difficult. It has been stated that free dispensaries will cease to exist, but this is only partly true, as undoubtedly there will still be indigent patients, who will not come under the provisions of the insurance law, and who will have to be provided for, just as at present.

Physiotherapy as War Work for Young Women

The Surgeon General's Office, War Department, has issued an urgent call for young women to serve in reconstruction hospitals at home and abroad. The Normal School of Physical Education, Battle Creek, Michigan, which is affiliated with the Battle Creek Sanitarium, wishing to do its share toward winning the war, has inaugurated a course in physiotherapy, which meets the requirements of the War Department. Courses begin October 1 and February 1. The length of the course is four months. The curriculum consists of anatomy, physiology, hygiene, bandaging, active and passive movements, hydrotherapy, massage, electrotherapy, and clinics. Frank J. Born, M.D., is the director of the school.

THE WAR: ITS HOSPITAL, MEDICAL AND NURSING ASPECTS

THE BLUE TRIANGLE HUT

How the Y. W. C. A. Gives War Nurses Comfort, Cheer,
and a Breath of Home—Blue Triangle Demanded by
Base Hospitals

BY CLARICE NISSLEY, Special Writer for United War Work
Publicity Campaign Department, Chicago.

The youngest nurse at Base Hospital No. 10 slipped back very softly to the bed of the youngest private. He was so obviously the youngest private. Ten days before he had thought he was "going west," he had laboring told her the lie that was bothering him.

"I told 'em I was eighteen and I'm not. I'm only sixteen," he had whispered in breaths that were very short. He had enlisted as a musician and had gone out with his regiment, playing. But in the thick of it he had dropped his cornet and had snatched the gun which the boy ahead was letting slip. Then he had gone on with the rest and the stretcher bearers had brought him in. "This war's no place for a musician," he had tried to smile.

He was sleeping just as the nurse had left him. His hair, ruffled where the bandage crossed his forehead, was moist and curling. On the white tray by his cot the nurse unrolled the napkin from the dish she was carrying. It was her own dessert. She left it where the youngest private would see it and again tiptoed out of the ward.

Out in the compound the youngest nurse, with thirty minutes left from her dinner hour, hesitated. Anxious thoughts kept jumping back into her head, worries about the youngest private, about the white-headed boy lying on



Fig. 1. Exterior of the Y. W. C. A. residence for nurses and employed young women, Camp Sherman Community, Chillicothe, Ohio.

the cot next to him, and the lad who had been brought in the night before with the wound that wouldn't stop bleeding. She wanted desperately to forget them for these thirty minutes. From the Blue Triangle hut at the edge of the compound came the sound of a victrola and she started toward it.

Dropped down by the side of row after row of hospital barracks, long barracks, inside whose walls eight thousand beds stretched up and down the corridors, the hut

looked no larger than an infantry's pup tent. It was an unstained pine building and on its doorstep was the bright blue triangle of the Young Women's Christian Association.

Sixteen Blue Triangle huts at base hospitals of the American army in France are supplying comforts for the American nurses in their few hours off duty. Frequently the one-room building is the only attractive place on the barracks compound. The rooms in which the nurses sleep are little different from the wards in which they work. Often mornings during the past winter their boots would be stiff and their washcloths frozen to the water pitcher. After the first few months, in which they waited as the American army itself was waiting, hearing of battles on the French and British fronts, but they themselves caring



Fig. 2. Interior of the Y. W. C. A. residence for nurses and employed young women, shown in Fig. 1.

for only a few cases of mumps or measles, they were swept into the night-and-day rush of the offensives. During both the tedium of the waiting and the weariness of constant duty, the Y. W. C. A. furnished to the nurses a place for rest and recreation.

At night, when the nurses come off duty, a Y. W. C. A. secretary at the Blue Triangle hut is waiting to give them a cup of hot chocolate. Hot tea and wafers are ready for them at any time during the day. There are magazines and books, often a victrola, comfortable chairs into which they may drop for just a few minutes' rest, and, best of all, conversation and laughter that has nothing at all to do with sickness.

In some cases the club rooms are part of a building designed to house both the Y. M. C. A. and the Y. W. C. A. work. In others the nurses' center is a separate building. In one city an old bar room of a hotel which before the war was famous for its sporting crowds was the only place available for the Blue Triangle room, but it is now a cozy sitting room. A few rugs and chairs, pictures and war posters, dishes of Breton ware bought at the little French shops, have made the difference.

"This village is a well-known watering place," writes Miss Marion E. Porter, the Blue Triangle secretary at Base Hospitals No. 23 and 36. "It is far up in the foothills of the French mountains and is quite famous for its wonderful spring water. We have golf links, polo grounds and eight tennis courts.

"In the summer we expect to use the race course as a baseball ground, and this is surrounded by a lovely park with benches, shady walks, a lake and several springs. The scenery in the vicinity of this village is magnificent, and as soon as the weather is warmer we shall take long walks and combine exercise and pleasure in visiting some of the neighboring villages to see the lace makers; this spot is the greatest lace center in France."

Near the Blue Triangle foyer are tennis courts where

the nurses can play when they are not too tired. On Sundays groups of girls relieved of duty start off with the secretary for an all-day tramp and a picnic. French classes are well attended at all the centers, lectures and entertainments are regularly provided, and on Sundays there are vespers and Bible classes. Change of thought and vigorous, outdoor exercise for every nurse, in spite of German offensives, air raids, or a daily inrush of *blesses*, is the task which the Young Women's Christian Association has undertaken. Occasionally there is a party, a birthday celebration for some nurse or doctor, for which the Blue Triangle secretary saves sugar for weeks ahead and brings it forth the final evening as the big surprise. It may be that the party, just nicely started, is suddenly interrupted with the command, "Prepare for patients," but even though the nurses hurry from the Blue Triangle hut to the operating room, partyless, they have had the pleasure and stimulation of making the plans.

"I feel as though I had been running a Blue Triangle hotel rather than a hut for nurses during the past month," Miss Willie Young of Charlotte, N. C., wrote from one base hospital, "for Base — has been used as a starting point for the extreme front for our numerous teams of nurses and doctors and then a gathering point for them on their way to their base, and in between these regular operating teams there has been that steady sprinkling of 'casuals,' wandering, disconnected souls of the A. E. F. who have no base or goal or resting place of any kind. They stay a few days and then, like Poor Joe, keep a movin' on. They can receive no mail while they are in France, as they can never be located, so their road is an isolated one in the midst of crowds.

"During all the moving our original one hundred and thirty-five nurses are sticking to their tense task with hardly an hour off in the day. Stone floors in the wards make their feet ache after hours of standing and the extreme suffering of plucky boys from this last victorious drive simply takes the life out of one. The hut stands to them as a glimpse of the normal, the outside, and a breath of home. It is so close to the wards that if the nurses have ten minutes off they can run over, drop in a chair, and just sit and be quiet."

One hundred and eleven women are now in France working for the Y. W. C. A. Besides its nurses' huts, the American organization is operating hotels for the American women in Paris and the girls of the United States Signal Corps, and Blue Triangle foyers for the girls of the munition plants. There are now fifteen Y. W. C. A. *Foyers des Alliées* where French girls are provided with entertainment, reading matter, and a comfortable clubroom in which to rest. As rapidly as possible the work with both the French and American women is being extended. Already requests for Blue Triangle huts have come in from six additional base hospitals and others will follow with the arrival of more hospital units overseas. They will be met as quickly as funds and workers are available.

* * *

American Nurses' Club in London

To meet the need of American nurses in France the London Chapter of the American Red Cross has founded the American Nurses' Club at 42 Grosvenor Place, London. This is intended to be the nurses' headquarters in England.

The Countess of Granard, formerly Miss Beatrice Willey, New York, has given up a floor of Forbes House to start an annex to the nurses' club. Bedrooms are available for the use of members at the nominal charge of

half a dollar a night; theater tickets are often put at the disposal of members and the committee in charge arranges for drives and excursions through London. The committee is as follows: Viscountess Harcourt, chairman; Mrs. Carnegie, Mrs. R. W. Chaplin, Mrs. Craig-McKerrow, Adele, countess of Essex; Mrs. E. B. Lane, Mrs. Powell, Mrs. Tobey and Mrs. Delany. The club is financed by the American Red Cross.

* * * *

WORK OF THE AMERICAN WOMEN'S HOSPITALS IN FRANCE

Second Unit Sails—First Military Hospital Established by American Medical Women in France—Personnel of Unit

The second unit of the American Women's Hospitals has just sailed for France. This group will be added to the staff of the military hospital directed by Dr. Barbara Hunt which, in cooperation with the American Committee for Devastated France, is working with the Sixth Army Corps. The hospital will contain one hundred military beds, with capacity for expansion to meet the utmost needs of the Sixth Army, and a small civilian ward. The group consists of: Dr. Caroline M. Purnell, Philadelphia; Dr. Mary L. Evans, Middletown, Conn.; Dr. Charlotte Fairbanks, St. Johnsbury, Vt.; Dr. M. Ethel Fraser, Denver; Dr. Mary McLachlan, Portland, Ore.; Dr. Ier Jay Manwaring, Norwich, Conn.; Miss Mary MacCully, Philadelphia; Miss Julia C. MacAlister, Philadelphia; Miss Agnes MacLachie, Philadelphia; Miss Margaret B. Purvis, Atlantic Highlands, N. J.; Miss Florence Chapmen, Montville, Conn.; Miss Wilhelmina Drummond, Atlanta, Ga. This is the first military hospital established by American medical women in France.

Dr. Hunt sailed early in June with two other members of her staff. The hospital completely equipped was established in a chateau at Neufmoutiers, August 1. This hospital included fifty military beds, but it had hardly been established before Dr. Hunt was asked to increase it to one hundred military beds and to go nearer the front. This has been done and the hospital is working near the base of the Sixth Army.

With the second unit has sailed Dr. Caroline M. Purnell, special commissioner for the American Women's Hospitals in France. Her mission will be to inspect this military hospital, to consult with the French medical authorities, and the American Red Cross in Paris and to survey the field generally. She will also discuss with the chief surgeon having the matter in charge the establishment of a mobile gas hospital which the American Women's Hospitals under the advice of the French military authorities are establishing for the French army.

Miss Jean Pattison, a third-year medical student at Cornell, has spent her vacation as a volunteer worker in France, and since July has been on the staff of Dr. Barbara Hunt. When Dr. Hunt was asked by the French authorities to go to Meaux to help in an emergency, Miss Pattison went with her. For her work at Chateau Thierry with the American troops she received special commendation. The following letter gives a description of some of her experiences there:

"Dr. Hunt was just going to Paris on Sunday, July 22, when she received word that the French hospital at Meaux needed help. She and Miss Pettingell, Miss Merrick and I went at once by motor and got there about seven. The hospital *médecin* chef told us to report at eight in the morning. When we went into the *triage chirurgie* that morning we saw a large room with six surgical tables and *blésés* everywhere—on stretchers or sitting up waiting their turn. The men came in from the field and went first to the main *triage* where *les dames anglaises* gave

them coffee and lemonade and they were given their blankets and sent over to the *triage chirurgie*. Five of the tables were in charge of French doctors with a nurse and orderly for each—the sixth was given to us. The *brancardiers* brought the *blésés* to us, and as soon as we finished with one another took his place. We alternated, Dr. Hunt and Miss Pettingell with Miss Merrick and myself and worked eighteen hours one day and thirteen the next, so that we were on duty only over night. The *poilu* is the most wonderful patient I can imagine—quiet and plucky and yet so utterly weary. During the first few days we had a thousand a day, but as the offensive moved west we got less and less. *Poilus* would walk in when it seemed impossible they could even move. One of my patients walked thirty kilometers with a broken arm and scalp wound. Some of them would get so excited telling about the battle that they would scarcely stay on the table. Comparatively few had only one wound. The orderlies were *poilus* and my particular one was a most grubby little one, but after I had worked with him a day I knew I could never live happily again without him. They were so quiet and gentle with their wounded comrades and in the ten days we were there I never heard one get cross or impatient.

"After we had cut off the soiled clothing and examined and dressed the wounds we wrote the diagnosis on the outside of an envelope and directed whether they could be evacuated at once to Paris by boat or train, or, if they were fractures of the skull or leg or penetrating wounds, which hospital they were to go to.

"Some of the men came in with paper bandages on their wounds. They were taken from the *boche*, an orderly told me.

"The people at home who are making surgical dressings ought to know how their work is appreciated over here. At Meaux there were plenty and it was the greatest help in the world. *Les dames anglaises* had pajamas too and these were a great comfort. The French do not use the lower part and when an American girl put them on a *poilu* in the *triage* one day the doctors and orderlies all came to see him and one remarked—'The Americans, so droll: They would make tennis players out of a *poilu*.'

"After five or six days things quieted down and Dr. Hunt and Miss Pettingell went back to the chateau, and Miss Merrick and I stayed for five days more. Then we were sent a telegram saying that the American hospital at Chateau Thierry needed help and to go by the first train. No trains were going through, but Captain Doreglas of the United States Army sent us over in one of his cars. It was a wonderful ride through the valley of the Marne with the trenches running through the ripe wheat field. It seemed impossible that that ground could have been fought over within the past week. It doesn't seem possible, but the grain isn't even tramped down. In some of the *boche* huts in the trenches we saw quilts and mattresses that they had taken from the villages near by. They lived comfortably but not long in those trenches. As we got further along many of the houses were completely destroyed. We got to the hospital and went on duty at once. The hospital was an old French one, but had been used by the *boche* so nothing was left there. The offensive had gone forward quickly and the wounded poured in so fast that we all had to do with what we had at hand, but it was terribly inadequate. Miss Merrick went to one postoperative ward and I to another and did everything we could to make the boys comfortable. All the water had to be carried some blocks and of course we had no heat nor light except solid alcohol and candles. There were plenty of blankets and that was the greatest comfort. The boys who were dying were awfully glad to have an American with them and their dying was not that of a worn-out invalid—they were strong and wanted to live.

"The boys who worked as orderlies were fine. I'll never forget one boy who was scrubbing dishes over a tin alcohol. I told him he'd be a candidate for Delmonicos when he got home and he grinned as he said, 'Not much, but gee, I can't help thinking what a help I'll be around the house after this.'

"After a few days a train came in and most of the cases were evacuated to a base hospital. The abdominal and the shock cases had to stay. One little Irishman in the shock ward asked me if I was his mother and I told him I was. After a little while he said, 'Are you my sister?' 'Yes, of course, I am,' I answered. The next time he wakened I went down and he said, 'Ah, you are

the Blessed Virgin, I knew you would come.' Just then Miss Grant came in and looking over at her he said, 'No, there is the Blessed Virgin. Will she go with me?' I told him reverently she would and he died quite happy.

"The Knights of Columbus and Y. M. C. A. brought the boys chocolate and cigarettes and they did appreciate them.

"Finally all left the hospital and we came back again to Neufmontiers. The aspect of the chateau had changed, and we found a hospital in its place with beds covered with gay blue spreads with an operating room ready and Dr. Hunt and the nurses more than ready for the patients. In a few days these began to arrive, old men and women and children undernourished and overworked. It is surprising how quickly they respond to rest, good food and good nursing. We all feel that the hospital has started in a short time considering all the unavoidable delay, and each day we see things going ahead and going ahead well."

WAR WORK OF SEVEN ORGANIZATIONS

Cooperation of Young Men's Christian Association, Young Women's Christian Association, National Catholic War Council, Jewish Welfare Board, War Camp Committee Service, American Library Association and Salvation Army

Seven organizations with the single purpose of doing their bit toward winning the war by helping to keep the military and industrial armies fit, are cooperating in a war drive beginning November 18, to raise \$170,500,000 for their war work at home and overseas. Each one of the seven has answered an imperative call. Each one is filling a definite war-time need. They all are chiefly concerned with the physical needs and the morale of the army. All have been engaged, since the beginning of the war, in service which has been recognized not only as "the greatest recorded demonstration of practical Christianity," but as a definite asset in the efficiency of the allied armies.

The Young Men's Christian Association, which is asking \$100,000,000 for its war work, is serving over three million soldiers and sailors in Europe and in the training camps of America. It is keeping a bit of home in the trenches and under the very fire of the enemy. The Y. M. C. A. hut at the front is the soldier's club, his church and his college, a place of entertainment, recreation, rest and study, and the quiet spot where he is provided with facilities for writing letters home. It is open to all creeds for service, from the early mass of the Roman Catholic to the later service of the Protestant clergyman and Jewish rabbi, and the song service held by the Salvation Army.

The Y. W. C. A., asking \$15,000,000, has gone into the war and war industries in behalf of the welfare of women and girls called to new and perilous work. It has provided proper housing and care, as well as recreation centers, not only for the munition makers of this country, but also for those of France, and its efforts have met with such marked success that the English government has asked its help in work of this character in that country. Already about one hundred hostess houses—"a bit of home within the camp"—have been erected at military camps at the requests of commanders, and a number are authorized and being built. It is also doing extensive work among the colored girls and foreign-born.

The National Catholic War Council, including the Knights of Columbus, asks \$30,000,000 to carry on its work. The Knights of Columbus have erected clubhouses at all the points of embarkation in this country and in France, as well as at the camps in America and "over there," where wholesome recreation is furnished and

a cheerful welcome awaits soldiers of all creeds. It has secretaries assigned to permanent duty aboard transports plying between this country and European ports, and one hundred K. of C. secretaries have just been ordered to Italy, where ten new buildings are being erected. A headquarters building is maintained in Paris and permanent clubhouses throughout London and France. A fleet of motor trucks, carrying cigarettes, tobacco, chocolate, writing material, soap and towels, and other articles, follows the rapidly advancing armies to provide our boys with "service under fire."

The Jewish Welfare Board, which will receive a \$3,500,000 share in the campaign, officially represents all national Jewish organizations in building up the morale of over one hundred thousand Jewish soldiers and sailors. It has erected clubrooms for soldiers, irrespective of race, supplied them with libraries of English, Yiddish and Hebrew volumes, and manned them with trained workers. Social rooms and sleeping quarters are maintained in camp towns. Jewish chaplains are serving everywhere in army work, and religious services are open to all. Welfare workers aid the families of soldiers and keep the boys at the front in touch with the homes they have left behind.

The Library War Service of the American Library Association, which asks \$3,500,000, has sent overseas during the past year more than a million books for the boys of our fighting forces. With quick, direct and loyal service, it supplies books for pleasure and for study. In all huts and canteens, the branch library offers the soldier or sailor recreation for his hour off duty in the form of suitable novel or magazine. In every ward of every military hospital, the book shelf is at the hand of the convalescent soldier. On every transport a deck library is at the service of the boy who would read. And each dollar given by the public for this purpose will circulate through the Association to the man in every branch of the service.

The War Camp Community Service, asking \$15,000,000, is a nation-wide movement for hospitality, conducted through a definite, well-ordered program, working in harmony with the training camp program of the War and Navy Departments. For the soldier or sailor off duty in a strange town, it counteracts the red-light lure with the greater attraction of wholesome recreation and thus speeds the man in khaki or blue on his overseas way with a keener enthusiasm to fight for a country in which he leaves no bitter, regretful memories. In April, 1917, the War Department Commission on Training Camp Activities was appointed by Secretary Baker, and the Navy Department Commission, by Secretary Daniels, and these commissions have cooperated with the Playground and Recreation Association of America, well experienced in this type of endeavor, in carrying on the work in communities outside of, and adjoining, camps, under the official name of the War Camp Community Service.

The Salvation Army, calling for \$3,500,000, carries its relief work into the very trenches and serves hot food to the men under fire. Every Salvation Army "hutment" has its cook stove and oven, and "lassies" with baskets of food stand under fire to give a hot cup of coffee to the men who are bringing up the ammunition. Truck loads of pies and doughnuts are sent daily from the bases to the extreme ends of the lines, and women officers darn and mend the clothing of the soldiers who come to the hutments for recreation. In this country, hotels and clubrooms furnish rest and entertainment near military and naval bases, with the usual church services held on Sundays.

QUERIES AND ANSWERS

Cleaning Operating Rooms After Septic Operations

To the Editor of THE MODERN HOSPITAL:

Please give us your opinion as to the best method of making a safe and practical sterilization of the operating room after a septic operation.

AN ALABAMA HOSPITAL.

It has been very definitely decided by authorities on the communicability of various diseases and pus organisms that soap and water properly propelled by hand and elbow power are the best disinfectants known, and that their free use is the only safe and sure method of sterilization for anything that cannot be put in a sterilizer and boiled.

Study, experience and laboratory tests have proved to us that we must have less and less faith in fumigation and disinfection as ordinarily practiced. Solutions of bichlorid, cresol compounds, formaldehyd and other disinfectants have little value unless the article to be disinfected can be immersed in them and left there for a definite length of time. This would hardly be possible to do with operating room tables or operating room floors and the casual wiping them off with these solutions is surely not disinfection.

When operating in an infected case it should be the duty of your operating supervisor and her nurses to see that the infected material is confined to the smallest possible area, and as soon as the operation is finished that this material is removed and isolated as soon as possible. Everything that can be should be subjected to live steam or boiled.

Floors, tables, and standards should be thoroughly washed with water and plenty of strong soap. Your operating room attendant should be provided with gloves for this work.

Sanitary Toilet Seats

To the Editor of THE MODERN HOSPITAL:

In planning the new additions to our buildings, considerable doubt has arisen in our minds as to the various kinds of bathroom furnishings advised and advertised. Would you care to give us your opinion as to the best and most sanitary type of closet seats?

Of course those which seem to be the best are also the most expensive. Is it really worth while to put so much money into that sort of fixtures?

CHAIRMAN OF BUILDING COMMITTEE.

The most satisfactory type of seats are those made of white enameled steel or porcelain or those made of hard rubber products and having the least exposed metal.

Wooden seats may be produced and sold for less money, but can not be as sanitary and they require a constant cost of revarnishing in their upkeep. There can be very little doubt that these fixtures which are made of better material are more economical in the long run and certainly a better means of protection from infections to your patients and employees.

"Don't be penny wise and pound foolish," applies to the building of a hospital as to a home or hotel.

Cubic Feet Per Patient in Isolation Hospital

To the Editor of THE MODERN HOSPITAL:

Will you kindly give me your opinion as to the number of cubic feet and square feet per patient required in a ward of an isolation hospital?

As several authorities consulted have varied opinions in regard to this matter, I will appreciate very much your valued advice.

A UNIVERSITY HEALTH OFFICER.

The reason you have had so many opinions on the subject is that each opinion is predicted on a different condition of affairs; for instance, it will require much greater spacing of patients where the windows are small and the ventilation poor, and not nearly so many patients can be put into a given area under those circumstances. In some of our newer isolation hospitals, where the windows are large and are opposite each other, so that there can be fresh air playing across the rooms all the time, you can readily understand that a great many patients could safely occupy a given area.

Taking the average window space, height of ceilings and the usual number of door openings, with an average outlook as to the free circulation of air from the outside, 80 square feet or 800 cubic feet would be a most liberal allowance. If the circulation of air is good through the ward or room, half that much space would be ample.

So you can see that your various opinions might all of them have been correct, each from its own standpoint.

Painting Hospital Wards

To the Editor of THE MODERN HOSPITAL:

We are contemplating painting our wards and have in mind a French bedroom gray for the walls and ceiling, with white woodwork. I am puzzled as to whether the walls should be flat or enamel. I feel that the enamel may be more easily cleaned, but am somewhat puzzled as to the effect of the gloss. The wards are well lighted. Have you any suggestions to offer as to color and the paint?

A SUPERINTENDENT OF A STATE HOSPITAL IN THE EAST.

French bedroom gray is considered a very good color for walls and ceiling. We would advise flat finish instead of enamel. After the paint is well seasoned, a coat of starch is advisable. It should be prepared as follows:

Take three large teacupfuls of thick boiling cornstarch and dissolve in half a paiful of cold water, stir thoroughly and boil. After it has boiled, strain it through a sieve and thin down to about one paiful. This should be put on the wall with a calcimine brush. Starching the walls preserves the paint; and when it is necessary to wash the walls the starch comes off with the dirt and leaves the paint fresh and new. After being washed, it should be starched again.

The following notice has been posted in every room or every department of Presbyterian Hospital, Chicago:

Save 1,000,000 Lives

MR. HOOVER tells us that if we economize in use of all food stuffs and avoid waste in all materials, we can shorten the war one year and save one million lives. Here is war work for each of us. I urge most careful thought and assistance on the part of everyone.

Nothing Too Small to Save
Save Everywhere and by so doing, help *Save Everything*

Save 1,000,000 Lives

ALBERT M. DAY, President.

NEW INSTRUMENTS AND EQUIPMENT

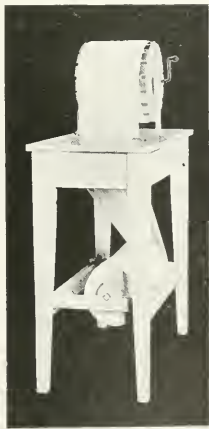
VINCENZ MUELLER, Technical Editor.
GEO. W. WALLERICH, Associate Editor.

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast avenue, Oak Park, Illinois.

Gauze-Rolling and Folding Machine

For the purpose of expediting the work of preparing surgical dressings, as well as economizing in the use of gauze, Miss Maud D. Woodward, R. N., of the Danville General Hospital, Danville, Va., has devised a simple and inexpensive gauze-rolling and folding machine.

The table on which the device is built is about 29 inches long, 16 inches wide and 46 inches high from floor to top of roller. The roller is 10 inches in length, 12 inches in diameter, and the circumference is 36 inches. The



Woodward gauze-rolling and folding machine.

gauze is placed on the roller below and is then divided by means of a rod which is situated on the under side of the table. This rod divides the gauze into 9-inch widths. The end of the gauze is fastened to the reel by means of three sharp pegs which hold it securely in place. The reel is divided so there are grooves 2 inches apart, which permit of cutting the dressings from 2 inches to 36 inches in length.

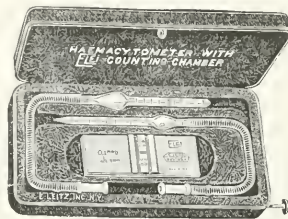
With this machine it is possible to cut 100 yards of gauze into 600 dressings 9 by 6 inches in fifteen minutes, while the same number will take about one hour's time if the work is done by hand. Thus it will be seen that this simple machine will be a great time saver. Likewise considerable economy in the use of gauze is effected.

A New Blood Counting Apparatus

Prompted by the numerous well-founded complaints in regard to the counting chambers' becoming loose in the cement and thereby exposing the user to considerable repair expenses, experiments were started by Mr. A. Traeger, of E. Leitz Company, New York, to construct a counting chamber of which the supporting surfaces for the cover glass and the slide itself are combined in the one piece in order to eliminate the cemented cell.

The new instrument, which is called the "Elei" blood counting apparatus, seems to have solved the problem in a most satisfactory manner, inasmuch as in this model the glass benches supporting the cover glass are a part of the glass slide, thus avoiding entirely the cementing chamber.

The "Elei" counting apparatus follows the parallel type of chamber as originally suggested by Dr. Buerker, which provides for a rectangular disc of glass with ruling, the disc extending entirely across the slide between the two



Counting chamber and diluting pipette.

parallel glass benches. Such a construction is said to prove a distinct advantage over the original "Thoma" model, which favors the circular disc, mounted in the center of a round chamber, cemented to the slide.

The manufacturers claim that the "Elei" counting chamber, parallel form, provides a more uniform distribution of the blood corpuscles than is obtained with the circular pattern, of which the chamber is entirely closed by the cover glass. Dr. Buerker has proved that atmospheric pressure does not effect the open and parallel chamber and consequently does not alter the actual depth of the solution film when counting blood corpuscles.

With the new counting chamber, when the cover glass is placed in position, the ruled rectangular disc remains 0.1 mm. beneath the lower surface of the cover glass. This construction allows the hollow space between the ruled surface and the cover glass to be filled by capillary attraction, after the cover glass is in position. By this method, the chamber is filled when touching the rectangular ruled disc under either edge of the cover glass with the tip of the filled diluting pipette. The glass benches for the support of the cover glass are elevated above the level of the slide and thereby permit the cover glass to be attached and also removed easily.

The manufacturers state that the construction of the "Elei" counting chamber closely observes the specifications of the U. S. Bureau of Standards. The tolerance of error, established by the bureau on May 1, 1917, is as follows: For the counting chamber—error of length of side of the large square not to exceed plus or minus 1 per cent, plus or minus 0.01 mm.; error in depth of chamber not to exceed plus or minus 2 per cent, plus or minus 0.002 mm.; for the diluting pipettes—error not to exceed 3 per cent in the principal interval.

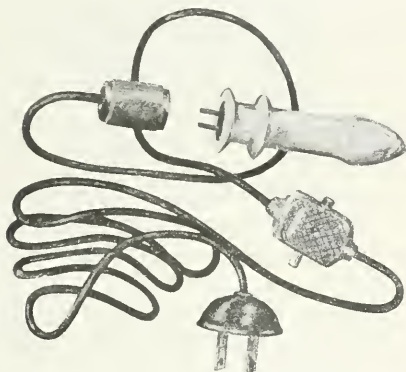
Electrothermal Applicators

A device called the "electrothermal dilator" is shown in detail in the accompanying illustration. The name implies that the purpose of the instrument is to apply electricity to certain parts of the body, but this is not a fact. It is used for the purpose of applying heat in the treatment of hemorrhoids, rectal fistula and rectal prolapsus, etc., and is so constructed that it is absolutely impossible for the patient to receive an electric shock.

The instrument on insertion produces a gentle dilatation of the rectum, and, after connection to the electric current, a continuous supply of heat is applied to the distressed organ. The heat rises gradually and can be maintained and regulated at any temperature that may be desirable in each individual case.

The body of the dilator is made of a hard, highly polished material which can be thoroughly sterilized without danger of injury. The diameter of the dilator is about three-fourths of an inch.

The heating system is constructed from a lasting alloy of nickel wire and sealed within the body of the dilator.



Electrothermal dilator and heat applicator.

The controller (with an "on" and "off" button of different colors) is inserted into a heavily insulated conducting cord about 4 feet from the dilator, the entire cord being 10 feet in length. The connecting plug is inserted into a serris plug which is furnished with the outfit, for the purpose of lowering the voltage of the street current to the required degree.

Where the commercial current is not available, five dry cells properly connected may be used, for which purpose cord tips are attached to the conducting cable instead of the attachment plug.

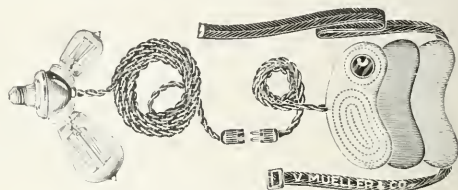
Urethral catheters or bougies of different sizes for application of heat can also be furnished, and these are so arranged that they can be attached in the same manner as the dilator.

Electric Pad for Applying Heat to the Eye and the Mastoid Region

The Goodwill electric heating pad was described in a former issue of this journal. Since then this pad has proved so satisfactory that I have asked the manufacturers to construct a small pad on the same principles as the large one, but of a size and shape that could be used for applying heat to the mastoid region and the eyes, and the outfit illustrated here is the result.

The pad is equipped with the Goodwill resistance wound thermostat, which permits of its being adjusted to exactly

the temperature required in any case. The reniform shape and its small size make this pad extremely useful for the purpose for which it is designed, as it fits nicely behind the ear, and it will be readily seen that



Electric heating pad for the eye and the mastoid region.

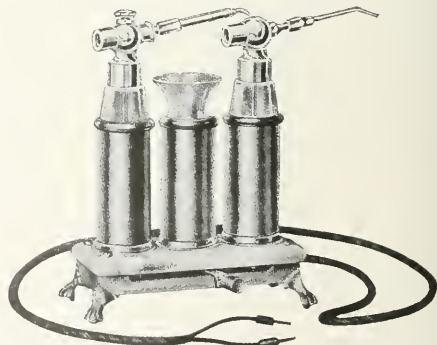
it can also be used to apply heat to either one or both eyes at the same time.

The pad operates in series with a 60-watt, 115-volt lamp on any voltage from 100 to 125. The small lamp as shown in the cut is connected in multiple with the pad. This has a tendency to limit the voltage in the pad itself and, in conjunction with the Goodwill method of sewing the heating element in place, makes the pad safe from short-circuiting.

The outfit is furnished complete with the Benjamin series plug, a large and small lamp, 12 feet of flexible cord, and a washable cloth cover, as well as a rubber

Electric Spray Heater

Owing to the fact that in cold weather oily substances incline to solidify and cannot be kept in perfect solution, considerable difficulty has been experienced in using the ordinary sprays for this purpose. Various spray heaters have been devised in the past, but, as a rule, the heat from an electric globe has been utilized, and this has never proved quite satisfactory. With the heater illustrated here, the temperature may be regulated so that the warm solution, which, as is well known, is more effi-



Electric spray heater.

cient and comfortable, may be administered; and it can even be brought to a boiling point if sterilization is necessary.

The center glass can be used for the purpose of melting wax or paraffin, or for the sterilization of laryngeal mirrors, etc.

The illustration shows cords with terminals for attaching to a parallel socket, but, if desired, it can be furnished with regular attachment plug for connecting to ordinary light socket. The device works on either direct or alternating current of 110 volt.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment, and Administration of Hospitals, Sanatoriums, and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XI

December, 1918

No. 6

EPIDEMIC INFLUENZA AND THE U. S. PUBLIC HEALTH SERVICE

Magnitude of Task of Relief—Cooperation of State Public Health Officers, the American Medical Association, the Volunteer Medical Service Corps, the Red Cross, the Medical and Nursing Professions and the Public—Preventive Measures—Important Research Undertaken

BY RUPERT BLUE, SURGEON-GENERAL, UNITED STATES PUBLIC HEALTH SERVICE, WASHINGTON, D. C.

IN sketching the activities carried on by the United States Public Health Service in connection with the recent epidemic of influenza, we go back to the summer, when unconfirmed reports reached this country that influenza was prevalent in Europe in pandemic form. On August 16 a circular was addressed to all the United States quarantine stations cautioning the medical officers to be on the alert in the inspection of vessels from European ports so as to detect any cases of the so-called "Spanish" influenza.

In this connection, it may be well to point out that maritime quarantine measures are directed principally to guard against the introduction into this country of exotic epidemic diseases, such as cholera, plague, yellow fever, and typhus fever. It would be manifestly unwarranted to enforce strict quarantine against diseases regularly quite prevalent in this country, such as typhoid fever, scarlet fever, measles, and the common respiratory diseases, including influenza. In accordance with these considerations and the fact that influenza is not a quarantinable disease, the quarantine officers were instructed, if such disease was discovered on in-coming vessels, not to release such vessels

from quarantine until after the local health authorities had been notified and after steps had been taken to prevent the spread of the disease from such sick persons.

Soon after this, the disease made its appearance in Boston and vicinity and in a short time spread in virulent form throughout the state of Massachusetts. Foci of the disease were also reported from other parts of the country, especially along the Atlantic seaboard.

In this situation it became apparent that the Public Health Service would be called upon to render assistance to local and state health authorities far beyond the allowances of its regular appropriation. It became imperative, therefore, to provide funds for emergency needs, especially since the epidemic threatened



Fig. 1. Influenza hospital organized by the U. S. Public Health Service in Washington, in quarters furnished by the War Department.

to disorganize the entire system of war production, munitions, mining, and ship-building, as well as the mobilization of troops. Accordingly, at the request of the Public Health Service, Congress adopted a joint resolution granting \$1,000,000 to the bureau for combating "Spanish" influenza. The very prompt action of Congress was as encouraging as it was gratifying, and the funds thus provided enabled the Public Health Service to enroll additional doctors and nurses

and send them in response to calls from stricken communities.

In the further description of the activities of the United States Public Health Service in dealing with the epidemic it may be well to consider these under two phases:

1. The provision of immediate relief for the stricken communities.



Fig. 2. Nurses in the emergency influenza hospital.

2. The inauguration and proper organization of measures for the relief and control of the epidemic in those parts of the country where the disease had not yet appeared.

Although the relief measures loomed large in the early days of the epidemic, the organization of preventive and relief measures in the non-stricken areas received a large share of attention from the outset. In fact, the two phases of work were carried on side by side.

RELIEF MEASURES

Some idea of the magnitude of the task confronting the Public Health Service may be gained from the fact that the requests for help from the vicinity of Boston alone included one for five hundred doctors, a number far in excess of those the service had available for such duty. Moreover it was clear, and subsequent events so showed, that, with the spread of the epidemic, similar calls would quickly come from other communities.

In response, therefore, to the urgent request for medical and nursing relief, all available regular officers of the Public Health Service were detailed to the stricken communities. Added to these was a force of trained nurses, temporarily detached from trachoma and other public health activities carried on by the Public Health Service.

Inasmuch as a large part of the country's medical and nursing personnel had been enrolled with the military forces, a request was addressed to the Surgeons General of the Army and of the Navy for a detail of doctors and nurses to aid the civilian authorities in providing emergency care in stricken communities. Unfortunately, the demands of the military population were themselves

so pressing, largely because of the widespread occurrence of influenza in the training camps, that very little help could be obtained from this quarter.

In this emergency the Public Health Service called upon the American Medical Association, the Volunteer Medical Service Corps, the Red Cross, the medical and nursing professions as a whole, and on the general public for personnel to help combat the epidemic. In response to the request for physicians available for duty in the Public Health Service, the American Medical Association and the Volunteer Medical Service Corps compiled lists of a large number of physicians classified by states. Appointments were offered by telegraph to these physicians by the Public Health Service, and within forty-eight hours groups of physicians were on the way to some of the stricken communities in New England. Soon afterward, similar medical units were sent to New Jersey, New York, Pennsylvania, Delaware, Mississippi, Montana, South Carolina, Virginia, West Virginia, Tennessee, and Arizona. In this connection, mention may be made of the fact that the Maryland Council of National Defense kindly placed at the disposal of the Public Health Service a fully equipped hospital train for use in its influenza work.

The problem of supplying nurses was much



Fig. 3. Graduate dietitians in the influenza hospital.

more difficult, for it was found almost impossible to discover nurses or trained attendants who were not already extremely busy on urgent medical work, mainly in training camps. A limited number of nurses and trained attendants were secured by the American Red Cross and mobilized for emergency service in the communities most severely affected. It was made clear from the out-

ganization of relief kitchens. In Washington a relief kitchen, under the supervision of Mrs. W. G. McAdoo, was opened at the old Emergency Hospital. Upon application, hot broth and gruel was delivered free of charge by automobile to any address in the city. This undoubtedly has relieved a great deal of the trouble.

A RESERVE CORPS TO DEAL WITH FUTURE EPIDEMICS

This epidemic has demonstrated, as never before, the imperative need of a permanent organization within the Public Health Service available for emergency work. To a large extent, such an organization can exist in skeleton form, but if

widespread epidemic outbreaks of disease or other great public health emergencies are to be dealt with successfully, steps must be taken to avoid having to create a new organization with each emergency. This difficulty has been met by the passage of a joint resolution, pending in Congress since June, 1917, which provides for the establishment of a reserve in the Public Health Service. The resolution became a law with the President's approval on October 27, and the organization of the reserve, which is now under way, will undoubtedly have a profound influence in safeguarding the health of the nation.

OUT-DOOR TREATMENT OF SPANISH INFLUENZA

Loss of Life During Recent Epidemic Greater Than That Caused by War—Open-Air Treatment Tried with Excellent Results—Statistics Prove Superiority of Open-Air Cure—Suggestions for Cubicle Construction to Handle Future Epidemics

By W. A. BROOKS, A.M., M.D., ACTING CHIEF SURGEON, STATE OF MASSACHUSETTS

PROBABLY the real history of the epidemic of the so-called "Spanish influenza" will never be known. Perhaps it is just as well that all of its horrors should not appear in print. It is necessary, however, that some of them should be known in order that proper precautions may be taken to guard against its probable recurrence next fall. When it is considered that this epidemic has already cost in the neighborhood of

years. It really is nothing new; yet its application to cases of influenza was, in the beginning, largely the result of experience. It was interesting to see how the problem worked out. The



Fig. 1. Street at Camp Wm. Brooks, Corey Hill, Mass.



Fig. 2. Hospital at Gloucester, Mass.

first tent hospital for the treatment of influenza cases was established by the recruiting service of the United States Shipping Board, with the aid of the authorities of the state of Massachusetts.

Between 5,000 and 6,000 men in training were crowded together in four or five ships stationed at East Boston. Out of this number about 1,200 cases of influenza and pneumonia developed. Three hundred and fifty-one of the worst cases

one hundred thousand lives—more lives than we have lost in the war with Germany—the magnitude of the catastrophe is perfectly apparent.

Open-air treatment for diseases of the respiratory tract has been known and practiced for many

out of the 1,200 were treated at the tent hospital, and of this number thirty-six patients died. Early in the history of the camp it was learned that the worst cases of pneumonia came from quarters on the ships where the circulation of air was the poorest.

This was the first hint towards the proper treatment. Later on, it became known, through the cultures from the throat and nose, that the epidemic was due, not to the influenza bacillus alone, but also to at least two, possibly three, types of the pneumococcus. Type three of the pneu-



Fig. 3. Street scene at Lawrence, Mass.

mococcus was apparently the most dangerous, and one for which there is as yet no known serum.

The reports from the autopsies at the naval hospital showed the presence of abscesses in the lungs, and, together with these abscesses, were areas of gray and red hepatization. The hearts in many cases were absolutely normal. Clinically, it had been noticed at the camp hospital that, as cases became cyanotic, the use of ordinary heart stimulants, such as digitalis and strychnine, had absolutely no effect; and, when it became known that the deaths were due, not so much to heart failure as to the fact that the lung area was markedly diminished, it became apparent why the heart stimulants had no effect. The patients were simply drowned.

These facts being known, the treatment demanded was that the patient should be given as much air as possible. Consequently, on pleasant days the patients were moved out into the air and sun. The resultant improvement was most marked and startling. Practically without exception, after a day in the sunlight, temperatures were lower at night than they had been in the morning. The attending physicians at the camp took courage, and, when cases were brought in

early enough in the disease, recoveries became more and more frequent. A great number of patients with single and double pneumonia got well, and it was interesting to see them returning to the ships sunburnt after such a serious illness.

An interesting comparison of some of the tent camps with indoor hospitals can be made. For example, in a small hospital near Boston, the number of patients treated during the epidemic was 87. Of this number, 29 died. At an out-door hospital at Barre, Mass., 114 patients were treated and only four of them died. A general hospital in one of the neighboring cities to Boston had about 76 patients. Out of this number, 20 died within three days, and 17 nurses came down with the disease. As I have stated above, out of 351 patients at the first tent hospital, only 36 died. These facts speak for themselves.

Without the figures being complete, it is safe to assume that, where cases of influenza and pneumonia have been treated in wards of general hospitals, the rate of mortality has run from 30 per

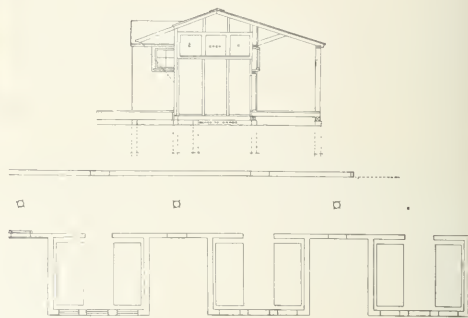


Fig. 4. First floor plan and elevation of cubicle construction suggested for out-door treatment of respiratory diseases.

cent to 50 per cent. In the out-of-door camps the rate of mortality has run from 5 per cent to 18 per cent. This in itself should be a convincing argument in favor of out-of-door treatment of this disease.

As an interesting contribution it can be stated that 3,000 boys training for the navy were put in the tents at Framingham, Mass., and at the end of two weeks, as far as I have been able to learn, in only 2 per cent did influenza develop.

It has been extremely difficult, however, to drive these facts home and to convince the medical profession that a patient is much better off *out of doors* than in *any* room with all the windows open. In such an epidemic as has recently swept this country it has been proven without

doubt that it is absolutely dangerous to treat ten or twenty cases in one room. The drop-sheet between the beds unquestionably make it less dangerous, but so many of the nurses in attendance are stricken with the disease that the efficiency of the hospital staff is greatly diminished.

Experience with this epidemic should revolutionize the construction of hospitals, and it is yet to be proved whether it is not inadvisable to treat twenty or more cases of any disease in a single room.

The great disadvantage of a tent hospital is that the nurses in attendance are very much exposed in bad weather. The patients in the tents can get along very well, but the nurses in attendance have no protection. Consequently, looking to the protection of the nurses as well as the benefit of the patient, the idea suggests itself of the building of cubicles facing the south, with room enough for two beds, and all of the cubicles connected on the north side with a passageway which might be heated in cold weather. On the north side of the passageway can be located the diet kitchen, hopper-room, and toilets. The space between the cubicles should be at least 9 feet. The shutters of the cubicles should all open inward, and the walls should not extend clear to the roof.

A second criticism of the tent hospital is that there is always a dead-air space at the top of the tent. Hence, it would seem almost advisable to

have the roof of the cubicle arranged in such a manner that it could be lifted.

The construction of these cubicles is much less expensive than the ordinary hospital construction, and it affords an opportunity of getting all the air and sunshine available. In addition, the front of each cubicle should be constructed in such a way that it could be opened out and in sunny weather the patient could be rolled out into the open so as to get the sun all day long. Every town of any size should have one of these cheaply constructed cubicle hospitals in order that on the outbreak of any epidemic the first few patients could be immediately taken care of. If many cases develop, the original units could be supplanted by others or by tents.

Personally, I am absolutely convinced that this would not only be a wise procedure, but an absolutely essential one if we are to be prepared for what is practically sure to happen. If it is not an epidemic of influenza, it will be an epidemic of some other contagious disease, and certainly this country has paid the price for its experience with this epidemic.

It has been roughly estimated that, in most communities, the value of a human life is about \$5,000. On this basis, there has been a loss to this country of practically \$500,000,000 during this epidemic, an estimate which should bring home to us the tremendous economic loss in an epidemic such as the one just experienced.

A HOSPITAL IN A FRENCH CHATEAU

One of the Hospitals on the Other Side Where Gas Cases Are Studied and Cared For



This beautiful chateau in Bellevue, France, was formerly the home of Isadora Duncan, the dancer. It is now (or perhaps we may write "was") the American Hospital for the Study and Cure of Gas Cases. If the need for its use for this purpose has not yet passed, it will, of course, soon be at an end with the cure of the cases now cared for, when "gas cases" will become the subject of a chapter on the gruesome curiosities of medical history.

AN ENGLISH HOSPITAL FOR AMERICANS

Good Results in the Care of Pneumonia Achieved in Unpretentious Architectural Surroundings

It would be hard to imagine a more complete contrast to the chateau pictured in the opposite column than this pneumonia ward of the American Red Cross Hospital at Mossley Hill, Liverpool, England, which looks more like a big drill hall than a hospital building. Nevertheless, the London department of information of the American Red Cross from which this picture comes, reports that the army doctors are enthusiastic about it, and call it the best thing of its kind in England.



A COOPERATIVE ECONOMY CAMPAIGN IN ALL DEPARTMENTS OF THE HOSPITAL

Savings in Chemicals and Drugs, Nursing and Housekeeping Supplies, Labor and Fuel—
The Human Element the Greatest Factor in the Economy of an Institution

BY ASA S. BACON, SUPERINTENDENT, PRESBYTERIAN HOSPITAL, CHICAGO

THE Presbyterian Hospital has been fortunate in securing splendid cooperation throughout all departments in the conservation program on which our government has asked us to act. We have always believed in avoiding unnecessary extravagance, but the war, by placing economy on the high plane of patriotic duty, has taught us many new ways to save and has intensified the

successful only if the utensils and material are clean and sterile; also, it should be made up with triple distilled water to get best results.

The polariscope test for sugar in the urine is much less expensive than chemical tests and is sufficiently accurate for clinical purposes. The initial cost of the polariscope is only about \$55, and its use has been a decided economy.

THE PHARMACY

A great many of the economies practiced in our pharmacy were explained in a former paper.¹

One of the advantages which the Presbyterian Hospital has always possessed from the point of view of economy in the pharmacy is the fact that the members of the medical staff prefer to confine their prescriptions, as far as possible, to official substances. There are great advantages in the use of pharmacopeial drugs. Not only are they required by law to meet a fixed standard, being staple substances, but they are also more economical to use than the non-pharmacopeial drugs.

We find it a saving to manufacture more of our



Fig. 1. Drug department, where the nurses receive four weeks' training.

interest felt in thrift. Everyone feels pride in having helped to eliminate waste without lowering the standard of service given, and this applies even to departments which in most cases feel no concern for expense and ordinarily resent being asked to consider this subject.

THE LABORATORY

It has been found possible to institute some very important economies without in the least hampering the work or injuring its quality. The extent of this saving may be indicated by the statement that in December, 1917, the cost of drugs used in one service alone was \$63, whereas in September, 1918, the cost of drugs for all services together was \$25.

This has been accomplished in part by a system of careful checking. The drug room checks the supplies requisitioned by the laboratory, and the latter checks the chemicals given out to the interns.

It has been found that to give out chemicals in dry form encourages waste. By giving out glacial acetic acid in solution, for instance, our laboratory has cut down the expenditure of one service for this chemical by three-fourths.

Another saving is effected by care in making tests. For instance, the gold chloride test is suc-



Fig. 2. Sorting room in the laundry. Damaged or badly worn linen is returned to the sewing room.

drug supplies than we might if our pupil nurses did not spend a month in the pharmacy. There is an immense saving in making syrups, essences, tinctures and elixirs. In the matter of manufacturing, no rule of economy can be laid down that will apply to all hospitals.

NURSING DEPARTMENT

In the nursing department our main economies are naturally in the use of gauze and cotton.

¹Bacon, Asa S., and Gray, William: Economy in the Hospital Pharmacy, April, 1918, X, 291.

We have replaced absorbent cotton to a large extent with non-absorbent; in fact, we use absorbent cotton only for eye dressings. We make applicators out of scrap cotton, and the plugs for specimen tubes out of waste cotton. Washed and resterilized gauze is, of course, used for dressings.

In many respects we have found economy no hardship. For instance, we find the bed-pads made out of old linen and padded with waste gauze preferable to those made of absorbent cotton. Perineal pads are made entirely out of small scraps of washed gauze.

HOUSEKEEPING DEPARTMENT

I have already told how we conserve food by the cooperation of patients in ordering from menus.²

Servings are, of course, watched to see that amounts of food in excess of what will be eaten are not given out.

The war, moreover, has given us a background from which to appeal to our domestic help for cooperation in economy, and they have responded as they would not otherwise. Before the war they would have felt injured, for instance, if they were not allowed to drink milk freely. Now it is possible to make them understand that milk is too much needed as a food to be used for allaying thirst by people who do not need it. Ac-



Fig. 3. Surgical supply department, where all waste gauze and cotton is made into dressings, bed-pads, etc.

cordingly, we have discontinued the serving of milk at the noon-day meal and do not permit it to be poured at breakfast and supper until the meal has begun and there has been a chance to satisfy thirst with water.

In the sewing room the opportunities for saving are endless. We cut down full-sized sheets, spreads and blankets, when worn at the ends, for

use in the children's wards. The bath towels used in the private pavilion are cut off and hemmed for use in the wards, later transferred to the help's quarters, and finally cut up into wash-cloths.

We have eliminated skirt gores in gowns for the sake of economizing material. The gores from the sleeves and back are used to make belts for nurses' gowns. Other scraps of new material are used for neckbands and drawstrings. We now use very little tape.

We used to employ sixty-inch rubber sheeting. Since the price of rubber has gone up we have made a considerable saving by using forty-inch



Fig. 4. A corner of the sewing room, where all waste material is reclaimed.

sheeting, piecing on old rubber at the sides to turn under the mattress. The old scraps are used for the scrub-maids' knee pillows.

A sudden demand for operating room masks was the occasion for the utilization of strips of new scrim left over from window curtains. Masks of this scrim proved cool and comfortable and made a "hit" with the surgeons and nurses.

A very simple record is kept of the cost of each article made in the sewing room, so that we know just what the saving is on each.

THE LAUNDRY

In the laundry the chief economy effected has been in the reduction of help through the use of faster machinery. We have put in a fast mangle, capable of turning out seventy feet of laundry, against thirty-five or forty-five formerly. We get as much work from one girl tending two fast presses tandem as used to be turned out by three body ironers. The use of pins has been discontinued, and paper bands are used instead.

THE POWER PLANT

We save in electric current and wear and tear of machinery by charging our signal system during the twelve night hours. We economize fuel by heating water with exhaust steam. Labor is saved by the use of the automatic stoker. Among

²Bacon, Asa S.: Cooperation of Physicians, Nurses, and Patients Enlisted Successfully in the Presbyterian Hospital, Chicago, July, 1917. IX, 21.

the materials saved in this department are oil and cotton. We collect the oil which drips on the floor around the machinery, filter it and use it again. We use scraps of washed gauze instead of waste in the engine room.

MISCELLANEOUS ECONOMIES

One of the most important miscellaneous economies is in the use of soap. When thoroughly seasoned, soap will not waste as it does when fresh. By cutting one pound bars in halves and thoroughly drying them on racks in the store-room for a year before use, the Presbyterian Hospital has been able to cut down its consumption of soap to a third of that of another institution which handles no more people.

We save in rubber gloves, in the first place, by buying a good quality, medium or heavy weight, standard sizes. Their life is prolonged as far as possible by patching. When no longer useful as gloves they are cut up, the wrists making rubber bands and the fingers being used as finger cots. The fragments that are past use are sold as old rubber. It is worth while, we find, to repair our own rubber goods, such as gloves and hot water bottles, etc.

The life of metal pails has been trebled by screwing to the bottom of each a wooden plug, which touches the floor and does not permit the metal bottom to sag. The top of the screw is soldered over to prevent leakage. It also makes the pail less noisy.

I had a special forceps made with a wide lip to squeeze the alcohol out of sponges. This forceps has entirely eliminated the waste of alcohol from squeezing the sponges with the fingers or with the ordinary forceps.

Cuttings from the folders in which histories are kept are cut up into cards, which are used for visiting passes, etc. Scraps of tissue paper, such as come around oranges and lemons, are saved and used for toilet paper for the help.

In fact, our aim is not to destroy, but to save and use every bit of potentially useful material.

THE HUMAN ELEMENT

After all, the largest factor in institutional economy is the human element. It is impossible to practice economy successfully with a discontented, disloyal force, or with a constantly changing force. For many reasons, an old employee who gives satisfaction is worth much more than an equally competent outsider.

The Presbyterian Hospital follows a policy which insures a contented, loyal body of permanent employees, who know our work and our ways. We pay what the employee is worth, and, if an individual has the capacity and ambition to advance, we give him or her the opportunity. The result is, our employees understand that the welfare of the Presbyterian Hospital is their own welfare, and they work for us not only with their hands, but with their heads and their hearts.

RESULTS

Ninety-six percent of our employees have stood by the hospital during the war and are still with us. They are all in fine physical condition and reasonably satisfied.

The amount of alcohol used has been reduced 50 percent. Chemicals used in the laboratory have been reduced 75 percent.

Shelf paper and paper used in dresser and linen drawers have been entirely eliminated.

Butterine is used throughout the house except for private room and special feeding patients.

Flannel bandages have been discarded entirely. Gauze bandage rolls have been reduced 75 percent.

The amount of gauze has been reduced 25 percent.

Lemons and oranges have been reduced 80 percent.

Sugar has been reduced 50 percent.

All meats and fats have been reduced 25 percent.

Similar reductions have been made in all departments where economy does not interfere with the service.



Fig. 5. This group of floor maids shows a part of the two hundred and fifty employees who have faithfully cooperated with the administration during the war. Miss Lucy J. Clark, matron, is standing at the left. The fourth standing on the left is Miss Ann Moore, who has given twenty-three years of faithful service to the hospital.

A LAUNDRY SYSTEM WHICH HAS PROVED SUCCESSFUL

Clean and Soiled Clothes Separated Through Entire Laundry Process—Triplicate Forms and Careful Checking Prevent Loss of Articles—Strict Economy Permits Use of Best Quality Supplies—Weekly Schedule of Patients' and Employees' Work

By MRS. LINA STRYKER FISH, GENERAL HOUSEKEEPER, MUNICIPAL TUBERCULOSIS SANITARIUM, CHICAGO

IT is rather the exception to the rule that the utilities of the hospitals or institutions are adequate for the census. In the case of this sanitarium, the exception is the rule as far as the laundry is concerned. The board and superintendent, with great forethought, have enlarged the laundry with the growth of the sanitarium, and the result is that we have a laundry fully equipped for our needs.

I thought it might be of interest to the readers of THE MODERN HOSPITAL to know something of the routine work here.

As in all well-organized places of this kind, it is an invariable practice here not to have soiled clothes cross the clean. One entrance is used entirely for soiled clothing, and the succeeding steps of the process take the clothes through the different stages until they are ready for delivery from the exit of the clean-bundle sorting room.

I will first tell of the collection of soiled clothing. Here, as in commercial laundries, the making out of the printed list is very important. My experience has been like that of everyone else in this line, that there are few persons who can make out a list properly. Our system, while it may seem complicated at first, proves after a little practice very efficient and easy. The persons using it grow to have such confidence in it that they adhere very closely to the forms.

The forms are printed on sheets of three colors, yellow, pink and blue, and are put up in blocks. They are used, of course, with carbons. The date and unit are designated at the top. Then comes the list of articles, alphabetically arranged and including every possible article, even to dust cloths. After the articles have been properly listed, the name and position of the sender are signed at the bottom. This assists in locating any articles lost. The yellow slip is retained by the sender, and the blue and pink slips are sent with bundle. The bundle system is used exclusively, the same as in commercial laundries, and it makes no difference whether the night gown and underwear of a bed patient or the flat work for a ward or cottage is being sent, the same system prevails.

When this soiled linen is received in the soiled-linen receiving room, if it is personal clothes, it is sent to the marking machine room. The flat

work, including bedding, linen, blankets, etc., is sent to the sorting room, for these articles have been marked before putting them into circulation. The clothes are opened, each bundle separately, and checked with the pink and blue slips. If there are any discrepancies between the bundle and the lists, the checker makes a notation beside the number marked by the sender; thus, if only three shirt waists are received and the blue slip says four, the checker marks both slips "3." After the bundles are checked, each article is looked over to see if it is properly marked, and, if not, the marking is done. As there is a special place on each garment for marking, this part of the work is comparatively easy. When this is done, the pink slip is sent to the clean-clothes sorting room, and the blue to the housekeeper's office. The pink slip is fastened on the box with a clip. An adequate number of boxes is supplied, which insures sorting for the clothing of each individual. The pink slip goes with the clothes until they are finished and made into clean bundles for distribution and is then returned with the bundle to the original sender.

The yellow slip retained by the sender must check with the pink and also with the blue retained in the office. In case of loss of articles, the complainant must go to the office with the yellow and the pink slips, and, as the office has the blue slip, it is very easy to give the final checking and place the blame where it belongs. The blue slip sent to the office also assists in the scheme for correctly crediting the laundry with the value of work done by it. Every article with its commercial estimate is entered on a ledger, so that we are able to say exactly what is its real value in dollars and cents. Thus you see the usefulness of making out laundry lists correctly and checking up with them as an aid in obtaining a grand total.

We also keep an accurate accounting of all our supplies, such as soap chips, Wyandotte soda, starch, and, in fact, to the ounce of bluing, so that at the end of the month we can tell exactly what it costs to accomplish the work as far as supplies are concerned, as well as the value of the work and supplies.

Another thing that is well to consider is the fact that, as far as is possible, unless they are

prohibitive in price and impossible to obtain, it is best to adhere to well-tried supplies. If substitutes are used, they should be worked out well before they are tried with the regular work. Of course, it is everyone's duty to obtain the simplest

on by the war. To show that our arguments are sound and can be substantiated, I will say that the biggest part of our flat work for beds, etc., has been in use for nearly four years. Results such as this can be obtained only by properly listed work and care in ordering supplies. It is but practical economy to keep the laundry to its highest grade, from the standpoint of regular service for everything going through it, and also for personal and bodily comfort, to say nothing of the appearance given in the working and using of articles laundered. Everyone wants to cooperate with the system, because everyone feels its value personally.

We have a very comprehensive method of collecting and delivering soiled and clean laundry. The lists for collection and delivery are made out in schedule form and placed in every unit of the sanitarium. Collections and deliveries are made by a truck, with a trained person to do the work. Each day's work is done at the regulation time on the schedule, and all clothing must be ready at this time to be picked up. One of our units is one-fifth of a mile from the other, with all the outlying cottages and buildings, so it is evident that a time schedule must be adhered to.

Monday at 8 a. m. all the wearing apparel of each employee is gathered, and this, with the flat work for every employee, is cleared up with the washing, while the patients' ironing, which was collected on Saturday's pick-up is finished up. On Tuesday the flat work is mangled and the ironing for the employees starts, so that work for employees and patients never goes through at the same time, either in the wash, or in the ironing. Wednesday is shirt and collar day, with the finishing of the employees' clothing, which is delivered the same day, leaving the last of the week, Friday and Saturday, for finishing up the work of the patients. Table linen, which we have for employees only, is sent every other day, and towels and kitchen articles, as well as specials for

M T S 3 10 12 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

CITY OF CHICAGO
Municipal Tuberculosis Sanitarium

ORIGINAL

LAUNDRY: Date _____ 191__

The following goods are herewith enclosed by _____

Section Designation.

No.	ARTICLE	No.	ARTICLE	No.	ARTICLE
1	Aprons—Colored	11	Diapers	21	Skirts—Dress
2	—White	12	Dresses	22	—Flannel
3	Bath Robes	13	Drawers	23	—
4	Bibs	14	Gowns—Laboratory	24	Sleepers
5	Blankets—Cotton	15	—Night	25	Socks
6	—Wool	16	—Operating	26	Spreads
7	Bloomers	17	Gumpees	27	Sweaters
8	Boys' Jackets	18	Handkerchiefs	28	Table—Cloths
9	Trousers	19	Hose	29	—Covers
10	Waists	20	Khaki Covers	30	—Tops
11	Brassieres	21	Kimonos	31	Ties
12	Bureau Covers	22	Mattress Pads	32	Towels—Bath
13	Caps	23	—Covers	33	—Dish
14	Chemises	24	Middy Blouses	34	—Glass
15	Children's Dresses	25	Napkins	35	—Hand
16	Cloths—Wash	26	Pajama Coats	36	—Individual
17	—Dust	27	Pants	37	—Roller
18	Clothes Bags	28	Pan Covers	38	Undershirts
19	Coats	29	Pants	39	Undervests
20	Collars	30	Pillow Slips	40	Union Suits
21	Combinations	31	Rompers	41	Vests
22	Corset Covers	32	Scarfs	42	Waist Bands
23	Cuffs	33	Sheets	43	Waste
24	Curtains—Long	34	Shirts	44	Wrappers
25	—Short	35	Shirtdiapers		

Date _____ Signed _____

Fig. 1. Laundry list used by Chicago Municipal Tuberculosis Sanitarium. Actual size, 5½ by 8½ inches.

and the most inexpensive things that will accomplish the purpose.

So far, by the strictest economy in their use, we have been able to continue with many articles we had used before the changes in price brought

MUNICIPAL TUBERCULOSIS SANITARIUM CITY OF CHICAGO		WORK PERFORMED AT LAUNDRY		DATE	
Laundry List Number	Laundry List Number				191__
1	2	3	4	5	6
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
25	26	27	28	29	30
31	32	33	34	35	36
37	38	39	40	41	42
43	44	45	46	47	48
49	50	51	52	53	54
55	56	57	58	59	60
61	62	63	64	65	66
67	68	69	70	71	72
73	74	75	76	77	78
79	80	81	82	83	84
85	86	87	88	89	90
91	92	93	94	95	96
97	98	99	100	101	102
103	104	105	106	107	108
109	110	111	112	113	114
115	116	117	118	119	120
121	122	123	124	125	126
127	128	129	130	131	132
133	134	135	136	137	138
139	140	141	142	143	144
145	146	147	148	149	150
151	152	153	154	155	156
157	158	159	160	161	162
163	164	165	166	167	168
169	170	171	172	173	174
175	176	177	178	179	180
181	182	183	184	185	186
187	188	189	190	191	192
193	194	195	196	197	198
199	200	201	202	203	204
205	206	207	208	209	210
211	212	213	214	215	216
217	218	219	220	221	222
223	224	225	226	227	228
229	230	231	232	233	234
235	236	237	238	239	240
241	242	243	244	245	246
247	248	249	250	251	252
253	254	255	256	257	258
259	260	261	262	263	264
265	266	267	268	269	270
271	272	273	274	275	276
277	278	279	280	281	282
283	284	285	286	287	288
289	290	291	292	293	294
295	296	297	298	299	300
301	302	303	304	305	306
307	308	309	310	311	312
313	314	315	316	317	318
319	320	321	322	323	324
325	326	327	328	329	330
331	332	333	334	335	336
337	338	339	340	341	342
343	344	345	346	347	348
349	350	351	352	353	354
355	356	357	358	359	360
361	362	363	364	365	366
367	368	369	370	371	372
373	374	375	376	377	378
379	380	381	382	383	384
385	386	387	388	389	390
391	392	393	394	395	396
397	398	399	400	401	402
403	404	405	406	407	408
409	410	411	412	413	414
415	416	417	418	419	420
421	422	423	424	425	426
427	428	429	430	431	432
433	434	435	436	437	438
439	440	441	442	443	444
445	446	447	448	449	450
451	452	453	454	455	456
457	458	459	460	461	462
463	464	465	466	467	468
469	470	471	472	473	474
475	476	477	478	479	480
481	482	483	484	485	486
487	488	489	490	491	492
493	494	495	496	497	498
499	500	501	502	503	504
505	506	507	508	509	510
511	512	513	514	515	516
517	518	519	520	521	522
523	524	525	526	527	528
529	530	531	532	533	534
535	536	537	538	539	540
541	542	543	544	545	546
547	548	549	550	551	552
553	554	555	556	557	558
559	560	561	562	563	564
565	566	567	568	569	570
571	572	573	574	575	576
577	578	579	580	581	582
583	584	585	586	587	588
589	590	591	592	593	594
595	596	597	598	599	600
601	602	603	604	605	606
607	608	609	610	611	612
613	614	615	616	617	618
619	620	621	622	623	624
625	626	627	628	629	630
631	632	633	634	635	636
637	638	639	640	641	642
643	644	645	646	647	648
649	650	651	652	653	654
655	656	657	658	659	660
661	662	663	664	665	666
667	668	669	670	671	672
673	674	675	676	677	678
679	680	681	682	683	684
685	686	687	688	689	690
691	692	693	694	695	696
697	698	699	700	701	702
703	704	705	706	707	708
709	710	711	712	713	714
715	716	717	718	719	720
721	722	723	724	725	726
727	728	729	730	731	732
733	734	735	736	737	738
739	740	741	742	743	744
745	746	747	748	749	750
751	752	753	754	755	756
757	758	759	760	761	762
763	764	765	766	767	768
769	770	771	772	773	774
775	776	777	778	779	780
781	782	783	784	785	786
787	788	789	790	791	792
793	794	795	796	797	798
799	800	801	802	803	804
805	806	807	808	809	810
811	812	813	814	815	816
817	818	819	820	821	822
823	824	825	826	827	828
829	830	831	832	833	834
835	836	837	838	839	840
841	842	843	844	845	846
847	848	849	850	851	852
853	854	855	856	857	858
859	860	861	862	863	864
865	866	867	868	869	870
871	872	873	874	875	876
877	878	879	880	881	882
883	884	885	886	887	888
889	890	891	892	893	894
895	896	897	898	899	900
901	902	903	904	905	906
907	908	909	910	911	912
913	914	915	916	917	918
919	920	921	922	923	924
925	926	927	928	929	930
931	932	933	934	935	936
937	938	939	940	941	942
943	944	945	946	947	948
949	950	951	952	953	954
955	956	957	958	959	960
961	962	963	964	965	966
967	968	969	970	971	972
973	974	975	976	977	978
979	980	981	982	983	984
985	986	987	988	989	990
991	992	993	994	995	996
997	998	999	1000	1001	1002
1003	1004	1005	1006	1007	1008
1009	1010	1011	1012	1013	1014
1015	1016	1017	1018	1019	1020
1021	1022	1023	1024	1025	1026
1027	1028	1029	1030	1031	1032
1033	1034	1035	1036	1037	1038
1039	1040	1041	1042	1043	1044
1045	1046	1047	1048	1049	1050
1051	1052	1053	1054	1055	1056
1057	1058	1059	1060	1061	1062
1063	1064	1065	1066	1067	1068
1069	1070	1071	1072	1073	1074
1075	1076	1077	1078	10	

the infirmary and the babies, are sent every day.

We are doing work for between eleven and twelve hundred people with a roster of five men and nineteen women, including the man on the truck who collects and distributes. They are divided into classified groups or crews for each particular kind of work, hand-ironing ironers, body ironers, shirt and collar workers, manglers, etc. Employees capable of being taught the work on the different machines are given this training, so

that we always have an understudy. Great care should be used in the organization of the work and in the selection of persons checking in, to see that they thoroughly understand the importance of that particular line. In no department of the hospital or institution is there more need for organization than right here. It is very essential to look after practically small matters, for they make the final success. The placing of the right people for doing special lines of work, the

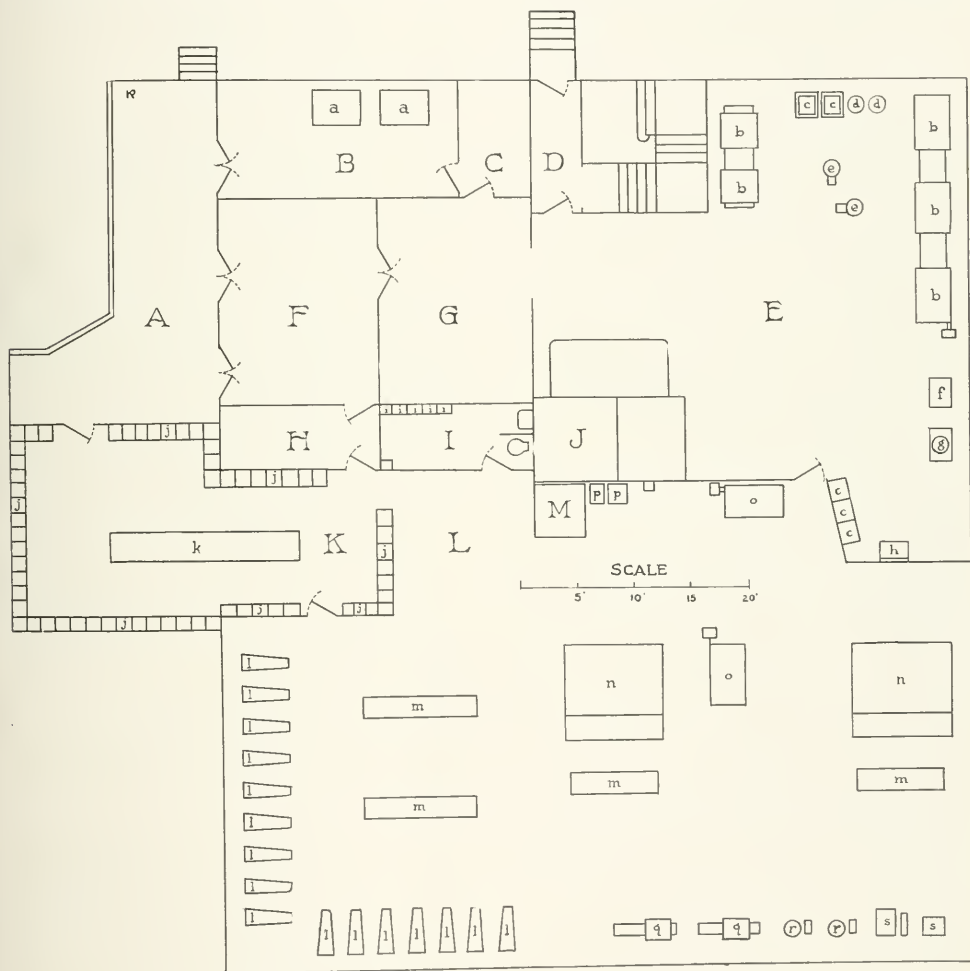


Fig. 3. Plan of the laundry of the Chicago Municipal Tuberculosis Sanitarium.

A. Platform
B. Soap room
C. Supply room
D. Hall
E. Wash room
F. Receiving room
G. Sorting room
H. Office

I. Locker room
J. Dry conveyor
K. Clean sorting and delivery
L. Ironing room
M. Dry room
a. Soap tanks
b. Washers
c. Tubs

d. Tanks
e. Extractions
f. Shirt starchers
g. Starch boiler
h. Sprinker
i. Men's lockers
j. Sorting boxes
k. Sorting table

l. Ironing tables
m. Tables
n. Manglers
o. Tumbler
p. Presses
q. Shirt ironers
r. Collar ironers
s. Body ironers

making of the bluing, the careful weighing out of the soap chips and the Wyandotte soda for soap, and the boiling of the starch all make a successful week's work.

If the foundation is well laid, you have results of which you can be proud. What gives greater

comfort than clean, sweet-smelling clothes? Good laundering is a service that is fully appreciated perhaps only when something calls attention to the want of it, and it is but practical economy to keep this service up to the highest standard of efficiency.

VENEREAL DISEASE CLINICS

The War Department Calls on the Hospitals of the Country to Establish and Maintain Venereal Clinics as a Necessary War Measure—Essential Requirements for Maintenance of Efficient Clinics

By MICHAEL M. DAVIS, JR., DIRECTOR OF THE BOSTON DISPENSARY

1. *Why combat venereal diseases?*—Because they are prevalent, contagious and dangerous.

Three million active cases of syphilis and gonorrhea in the United States today is a low estimate. Among some groups of the population the proportion is very much higher. Tests made of the adult admissions to a number of general hospitals in different parts of the country have usually shown 20 percent or more of cases of syphilis (not admitted as such).

Both syphilis and gonorrhea are contagious. They affect the present, and also the next generation. Their prevalence saps national stamina.

2. *Why combat these diseases now?*—Officially we are still at war, and the conclusion of peace will not mean immediate demobilization. Syphilis and gonorrhea are the most serious single causes of illness and inefficiency in the army. It has been demonstrated that the sources of these infections lie not within the army itself, but in civilian life. The War Department, the United States Public Health Service, the Council of National Defense, and the War Camp Community Service have therefore joined in a national campaign to bring every civilian community to take aggressive steps to control, treat and prevent venereal disease.

3. *Where do the hospitals come into this program?*—Adequate facilities for the diagnosis and treatment of syphilis and gonorrhea are one of the outstanding necessities. The treatment of these diseases requires special skill and equipment, and must be long-continued to be effective. For these reasons, the resources of private medical practice are recognized everywhere by health authorities as inadequate to provide for more than a small fraction of the cases of venereal disease.

The hospitals of the country are the chief institutions which have the equipment and the necessary medical organization out of which the needed organized clinical facilities can be built.

4. *Why have venereal clinics?*—Because the bulk of cases of syphilis and gonorrhea can and should be treated as ambulatory cases. Out-patient clinics are the chief means through which treatment facilities can be provided for them.

5. *Are hospital beds necessary?*—Yes. Not for the average case, but for a certain proportion of cases, the use of beds is highly important. Some patients are ill enough to require bed care for a period, and others can be kept under control only by being in an institution until the period of great infectiousness has passed.

6. *Have many hospitals successfully maintained such clinics?*—Previous to the war, a certain number of representative general hospitals had done so. During the present year, as a result of the war program, about a hundred additional hospitals have established such clinics, but it is still true that, out of over two thousand hospitals in the country doing public work, nearly 85 percent have as yet no clinics for venereal diseases.

7. *How are such clinics best maintained?*—It is best, when possible, to have clinics for the treatment of syphilis and gonorrhea carried on as part of a general out-patient department which has clinics for other diseases also.

Nearly half of the two thousand hospitals just referred to have some out-patient department already, of which venereal clinics could be made a part.

8. *What are the six essential requirements of efficient clinics?*—(1) Staff; (2) equipment; (3) laboratory facilities; (4) follow-up system; (5) social service; and (6) coordination with the local public health authorities.

Details of equipment and management will be outlined in a series of articles in THE MODERN HOSPITAL, beginning in this number, page 481.

9. *Need expense be an obstacle?*—No. In the first place, a number of representative hospitals have maintained such clinics without any net expense, by charging patients fees sufficient to cover

the cost. A large proportion can and will pay. Such *pay clinics* are not at all incompatible with maintaining a large amount of charitable or free work for patients who can pay little or nothing, any more than the maintenance of paying or part-paying hospital beds is incompatible with the charitable and free work of the same hospital.

As a further aid, a number of states have appropriated money to assist venereal clinics when they come up to officially recognized standards of efficiency.

The United States Government has appropri-

ated a large sum of money to fight venereal disease throughout the country. This money will shortly be available to the several states in proportion to population, and may be distributed by state authorities to assist local treatment facilities such as clinics.

10. *What should hospitals do now?*—If they have clinics treating syphilis and gonorrhea, make sure they are up to standard of efficiency as to all six requirements.

If they have not such clinics, do their part in a great national program by establishing them.

HEATING AND POWER PLANT ECONOMIES FOR HOSPITALS*

Coal Economy a Matter of Patriotic Duty and Personal Benefit—Huge Waste in Average Boiler Plant Preventable—Careful Survey of All Steam Plants Proposed—Fundamentals and Recommendations of National Economy Program

By D. D. KIMBALL, MEMBER NEW YORK STATE COMMISSION ON VENTILATION, PAST-PRESIDENT AMERICAN SOCIETY OF HEATING AND VENTILATING ENGINEERS

Never before have power plant economies assumed such importance as at this time. Last year's fuel scarcity is still fresh in the minds of all, and similar conditions are to be feared during the coming winter. Every fuel-user faces a patriotic duty which is, at the same time, a matter of personal benefit. Every ton of coal saved is so much energy released for the promotion of essential war industries and a bit of relief in freight congestion.

Dr. Howell has stated before this society in an admirable paper¹ that "about 10 percent of the expenditures of the average hospital are for the engineering department." Doubtless, owing to the present high costs of fuel and labor, this proportion of cost is now increased. No department of hospital maintenance will be found a more fruitful field of study to promote economies—not that hospital plants are more inefficient than others, but because the vast majority of heating and power plants are notoriously wasteful.

For years mechanical engineers have emphasized the possibilities of improvements to be made in the operation of heating and power plants, but little heed has been given to their statements. It has recently been stated that "it has been determined that the waste in the average boiler plant alone is 42 percent, the most of it preventable." It is certain that few plants are so equipped and operated that a 10 percent, or even 20 percent, saving may not easily be made in operating costs.

And a saving of 10 percent of the fuel used means much more in dollars than was the case two years or more ago. Millions of tons of coal must be saved to meet the excess of demand over supply, and this total saving must be accomplished by making some saving in every plant.

So important is this matter now considered by our government that a special bureau of conservation of the United States Fuel Administration has been formed and a careful survey of all steam plants is proposed. A form of "Standard Questionnaire Covering the Operation of Steam Power Plants" is to be sent to all steam-power plant owners, with a view, first, to securing more efficient operation of all plants to reduce fuel consumption, and second, of curtailing the allotment of coal to those plants which fail to comply with the recommendations of the fuel administration in regard to economical methods of operation.

The fundamentals of the national program are as follows:

1. Personal inspection of every power plant;
 2. Rating and classification of every power plant in the country into five classes, depending upon the thoroughness with which the owner conforms to the recommendations of the U. S. Fuel Administration.
 3. At the discretion of the Federal Fuel Administration, curtailment or complete stoppage of supply of coal.
- The standard recommendations of the United States Fuel Administration are substantially as follows:

1. *Fuel*—That means be provided for measuring and recording fuel used each shift or day;
2. *Water*—That boiler feedwater be heated by exhaust steam or waste heat, and measured;
3. *Air Supply*—That a correct amount of air be sup-

*This paper was prepared for presentation at the Twentieth Annual Convention of the American Hospital Association, but it was read by title only.

¹ Boiler Room Economics, 1915.

plied to the fuel, and that proper means be provided for measuring and regulating the draft.

4. *Clean Heating Surfaces*—That boiler heating surfaces be kept clean inside and out.

5. *Boiler and Furnace Settings*—That the furnace and setting be kept in good repair and free from air leakage.

6. *Insulation*—That exposed steam surfaces wasting heat by radiation be covered with suitable insulating material.

7. *Engine-Room and Heating System*—That, wherever possible, exhaust steam be utilized to the exclusion of direct steam from the boilers. (The plant should be designed and operated to produce no more exhaust than can be efficiently utilized in heating and process work).

8. *Supervision*—(I) That a competent employee or committee be detailed to supervise the work of fuel conservation in the boiler and engine plants; and (II) that a competent committee be appointed in charge of the work of fuel conservation in the buildings and shops outside of the power plants.

As long as the war lasts, no plant using coal for generating steam or for heating purposes can be considered too small to require the careful attention of some one within the organization. Fuel must be saved, no matter how small the quantity, and this is just the point which must be emphasized. Necessity has brought recognition of facts of which the interests of the fuel user himself should have long ago caused him to take heed.

As serious, however, as this condition now appears, a more enduring fact faces us. As high as is the present cost of fuel and engineering labor, the future cost thereof will not be materially less. For the future, therefore, as well as for the present, the promotion of heating and power plant economies is most essential.

The attention of those interested in this subject is recommended to the *Journal of the American Society of Mechanical Engineers*, July, 1918, "The Economical Use of Fuel."

Existing conditions warrant a careful consideration of those phases of the fuel consuming plant in which occur the greatest wastes, and means by which economies may be secured. In this connection, special emphasis will be laid upon those features which are most emphasized in the questionnaire of the Fuel Administration.

BOILER AND FURNACE SETTING

Although this is the fifth subject in this questionnaire, together with the matter of clean heating systems, it is credited with thirty-two points out of one hundred, so that it becomes exceedingly important that the best conditions should exist in the boiler installation and its operation. Special care should be exercised to keep the boiler clean inside, eliminating all scale and sediment. Similarly, the boiler must be kept cleaned on the outside. The tubes should be cleaned at least every day, and preferably on every shift. The collec-

tion of soot should not be permitted at any point.

The masonry work should be kept in good condition. It is often said that more fuel is wasted through leaky settings than in any other way. All cracks should be stopped up with some good filler and a coat of first-class plastic cement should be applied to seal all small cracks and pores in the brick. The settings should be gone over at regular intervals by a competent man. Good results are also obtained by applying elastic coatings which are available for this purpose. Access and clean-out doors should be made thoroughly tight. Leaks about the blow-off and other pipes connected to the boiler should be eliminated. The grates should be of the best design and in good condition. Warped, broken, or otherwise defective grates should be replaced.

Twelve points out of one hundred in the questionnaire are allotted to the matter of air supply. Insufficient draft or an excess of draft seriously affects boiler efficiency. The smoke connections from the boiler to the chimney should be well and tightly constructed. An adjustable damper in the throat of the smoke connection of each boiler should be provided and another damper in the main smoke connection. The latter should be automatically controlled by an approved damper regulator. Every boiler should be equipped with a reliable draft gauge, so that the engineer may determine whether his draft is at all times sufficient. A proper draft gauge would also tell whether the fire is too thick or too thin, whether it is evenly spread, or whether holes in the fire bed exist, and whether, in the case of battery boilers, some boilers are overloaded, while others are lagging.

It is often found in large plants that more boilers are operated than are necessary, with a lessened efficiency. In some cases boilers are unnecessarily and undesirably overloaded.

AUXILIARY EQUIPMENT

All boiler trimmings should be kept in good condition. Pumps should be of an efficient type and free from leakage. Feed water heaters are most essential. It is generally allowed that for each ten degrees increase in temperature at which the feed water is supplied to the boilers a 1 percent saving is made in the fuel, this being exceptionally true where the heating of the feed water can be accomplished by the use of exhaust steam or by utilizing the heat by the waste gases. A feed water filter is also desirable to eliminate scale and sediment forming elements from the feed water.

All traps should be examined to see that they operate properly and do not leak. Many instances are found where traps are wasting hot water to

the sewer, when this water, and especially its heat, might be saved. All hot surfaces should be thoroughly insulated. The pipe covering should be kept in repair. All flanged joints should be covered. No hot surfaces, whether carrying steam, condensation returns, drips, or hot water, should be uncovered in any portion of the plant.

For the hot-water supply of the building, storage heaters should be provided. Automatic thermostats controlling the temperature of the water should be provided. The distribution of the hot water from the hot-water tanks to the fixtures in the building should be by means of a circulating system, and the hot-water tank and all hot water piping should be covered with asbestos.

Proper coal and ash handling equipment should be provided to lessen the labor of the operating force, so that more attention may be given to the economical operation of the plant.

EFFICIENCY DETERMINATIONS

Relatively few hospital plants are equipped with devices which make possible the determination of the efficiency in operation. Only by the use of fuel and water measuring instruments can a correct determination of the efficiency of a plant be had. Every pound of coal and water fed to the boilers should be measured.

Reliable coal scales are a most essential element in every plant, but without means of measuring the water the results obtained from fuel burned are at best a matter of guess. The water fed to the boilers may be measured by means of Lea Feed Water Recorder or Venturi Feed Water Meter, or steam flow meters may be applied to the main boiler connections. In large plants the use of steam flow meters in the main supply and the different departments is highly desirable. In this connection, the uniform feeding of boiler with both coal and water is most desirable.

With the quantity of coal fired and water fed to the boilers known, a simple calculation determines the amount of water evaporated per pound of coal and roughly determines the efficiency of the plant, for a more exact determination of the temperature of the feed water and the heat value of the fuel should be determined, the former by a reliable indicating or recording thermometer, and the latter by an analysis of the fuel by means of a bomb calorimeter. The former is warranted in all plants, and the latter in large plants. For small plants, an analysis of the fuel can be had in many commercial laboratories. The value of the draft gauge has already been mentioned. It is often desirable also to determine the temperature of the waste gases. In addition, an analysis of the waste gases is emphasized by many authorities and is highly desirable in large plants. The

percentage of carbon dioxide present in the waste gases gives a very clear indication of the efficiency of the fuel combustion.

All the data obtained from the intelligent use of these instruments should be written systematically on a specially arranged log sheet and a daily calculation should be made to determine the efficiency of the plant. The result of this calculation may helpfully be plotted upon a sheet, showing the progress made in increasing the efficiency of plant operation.

PLANT OPERATION

In the operation of the plant, proper fuel selection and intelligent operation will inevitably bring about the best results. Just at this time, the proper selection of the fuel is a difficult matter, but its intelligent use is most essential. Low-priced labor in the boiler and engine room is always most expensive. Skilled service, even though at high wages, is always most economical. Nothing should be permitted to interfere with the principal duty of the chief engineer, which is the proper supervision and economical operation of the heating and power plant, and daily report as to the results of the plant operation should be required of him. He should be held responsible not only for the operation of the plant, but also for its maintenance, for the upkeep of repairs, and for the appearance of the plant. The prevention of leaks and wastes should be most rigidly insisted upon, this applying both to the heating and plumbing system.

Experts in the economical operation of power plants should be employed to consult and cooperate with the operating force of every large heating and power plant. The proper selection and installation of the instruments herein referred to are not sufficiently understood by the average operating engineer. Neither is that use of these instruments which will promote maximum efficiency in plant operation thoroughly understood. To both should be applied the judgment of thoroughly experienced designing and operating consulting engineers. Patriotism and self-interest urge zeal and promptness in these matters.

The Merchants' Association of New York City, in a letter sent by its Committee on Pollution and Sewerage to Director General William G. McAdoo of the U. S. Railroad Administration, urges the installation of suitable sanitary devices in railroad trains to protect water courses adjacent to railroad rights of way from contamination by the discharge of the contents from train water-closets. The use of a "sealed closet" is recommended, and it is believed that its installation on cars built during government control of the roads would be inexpensive.

Those who can take the lead are given the lead. If they neglect this opportunity, theirs is the responsibility for the failures which must ensue.—Arthur T. Hadley.

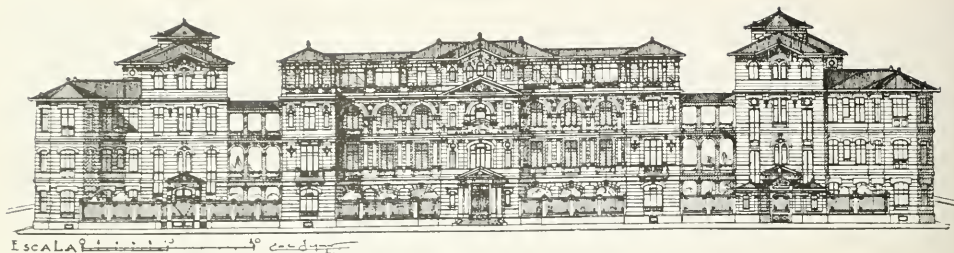


Fig. 1. Administration building or main front of the Roberto del Rio children's hospital.

THE HOSPITALS AND THE HOSPITAL SYSTEM OF CHILE^{*}

A Highly Centralized System, in Which Private Charity Is Administered Under Government Control—Hospitals of Santiago, Valparaiso and the Provinces —Schools for Nurses and Midwives

BY M. K. CHAPIN, MANAGING EDITOR OF THE MODERN HOSPITAL, CHICAGO

The hospitals of Chile appear to be organized on a plan which presents some rather interesting and, to people in this country, unfamiliar features. In theory, at least, Chilean hospitals are apparently not regarded as functions of the state. They are favorite objects of private charity. We are told, for instance, of the prevalence in the provincial city of Antofagasta of the admirable custom of honoring persons deceased, not by perishable funeral wreaths, but by gifts to the local hospital¹; and a similar practice seems to be not unknown elsewhere in Chile, for, here and there among the records of substantial bequests and donations, running up into hundreds of thousands, to hospitals in various places, appear such items as the gift of 940 pesos (about 340 dollars) from the medical society of Concepción to the children's hospital of that city in honor of the recently deceased Dr. Roberto del Rio. Again, we read that, a certain hospital being about to close its doors for lack of funds, a private citizen (a candidate for the senatorship, by the way) in that province came forward with the offer to pay its expenses out of his own purse.²

Few Chilean hospitals, however, are autonomous private institutions. Of the 108 hospitals existing in the republic in 1915, all but 7 were controlled by local quasi-governmental boards of charities (*juntas de beneficencia*); and these local boards were in 1917 placed under the control of a superior council of public charity (*Consejo Superior de Beneficencia Publica*). Thus the hospitals are under a highly centralized form of control.

The principle on which these local boards were originally organized was supposed to be that of independent subsistence on their own individual funds, together with the contributions of charity. The proportions contributed by the central government and by the municipalities, however, have increased from year to year until the *juntas de beneficencia* have been transformed from private institutions into public services, maintained chiefly from government funds.⁴ Of the 8,528,043.58 pesos (about three million dollars) spent by the hospitals in 1915, 4,165,959.66 pesos, or nearly half, was contributed by the central government; 66,752.59 pesos was given by the municipalities; 443,384.10 pesos came from private donations; and 3,813,877.23 pesos was the income from the property owned by the *juntas de beneficencia* themselves.⁵ Although the constitution and the law require the municipalities to maintain charitable institutions, they are unable to fulfill this obligation unless aided.⁶

In August, 1917, the president of Chile issued a decree establishing a superior council of public charity intended to unify the action of the various local boards, to advise the government with regard to the distribution of public funds and the plans offered by the departmental *juntas*, to draw up a plan for the organization of the services, etc.⁷ The members of this central council are chosen in part by the national government and in part by the local boards. The council publishes a quarterly review, the *Revista de Beneficencia Publica*, on information contained in the various numbers of which this article is based.

^{*}This article is a collective abstract, drawn from articles contained in the *Revista de Beneficencia Publica*, the organ of the Consejo Superior de Beneficencia Publica of Chile. All of the following footnotes refer to this review. The accompanying illustrations are from this periodical.

¹ *Cronica*, March, 1918, II, 1.

² *Cronica*, September, 1917, I, 95.

³ *Cronica*, September, 1917, I, 93.

⁴ Santelices, R., Philippi, J., and Gormaz, J. M.: *Los Impuestos a Favor de la Beneficencia*, November, 1917, I, 293.

⁵ Philippi, J.: *Discussion*, October, 1917, I, 158.

⁶ *Creación del Consejo Superior de Beneficencia Publica*, September, 1917, I, 90.

GENERAL VIEW

The 108 hospitals existing in 1915 offered a total of 10,395 beds, of which 9,468 were free and 927 for paying patients. The hospital provision for men consisted of 5,778 beds, and that for women, of 4,617 beds. The total personnel consisted of 36 resident and 364 non-resident physicians, 19 pharmacists, 539 nuns, and 2,954 em-

Santiago, the capital, possesses, in the Hospital de San Juan de Dios, the oldest hospital in the country, whose foundation in the middle of the sixteenth century dates back to the conquest, or at least to the *conquistadores*. The Junta de Beneficencia de Santiago, founded in 1819, is likewise the oldest of the local boards, besides being the most active (it organized the first congress of

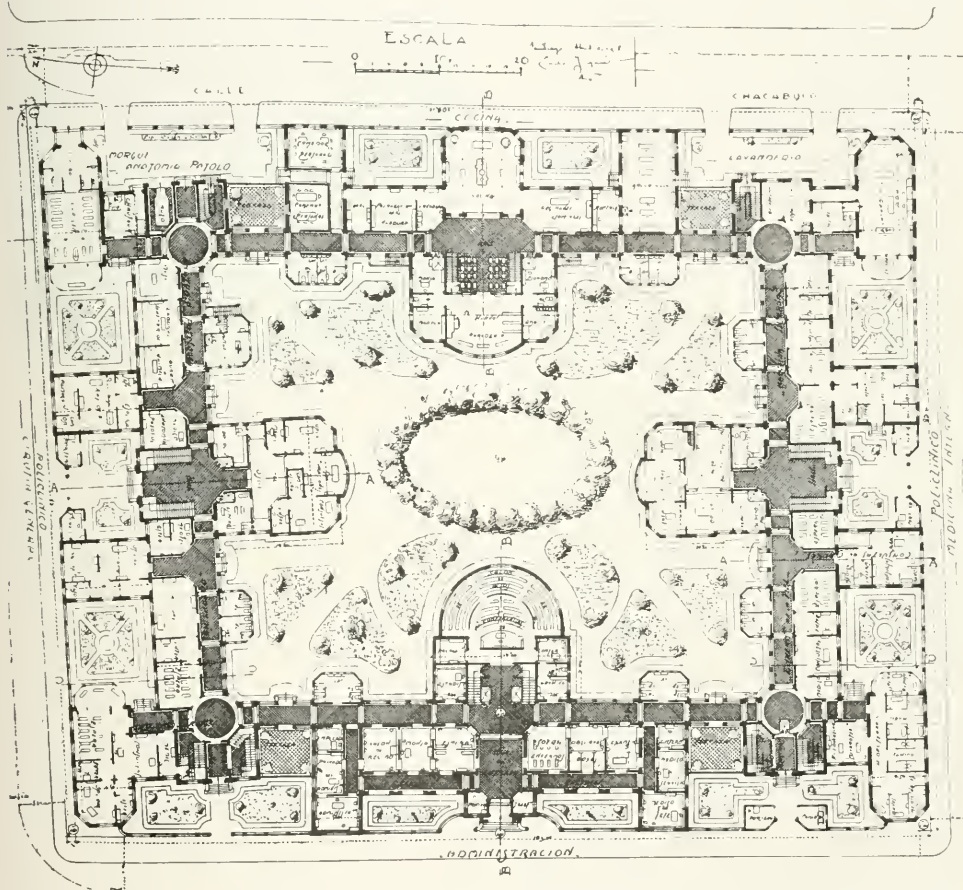


Fig. 2. Ground floor plan of the projected 425-bed children's hospital in Santiago, the Roberto del Rio. This is to be a four-story edifice, occupying with its grounds a city block. It is built around a hollow square and really consists of four separate buildings, connected at the corners of the square by open galleries, which permit a free circulation of air in the court within. The western building (lower side of cut) is the administration building, with a lecture amphitheater back of the reception rooms. The southern side (right of cut) is devoted to the internal medicine polyclinic and wards, with a section for infectious diseases. The north side contains the surgical polyclinic and wards, with a section for infants. The east side (top of cut) contains the morgue and laboratory of pathologic anatomy, the clinic and wards, with a section for personnel, with rooms for the sisters, nurses, and servants above. The scale on the plan represents 20 meters (about 65 feet).

ployees.² The death rate of Chile is high (29.04 per thousand)⁷ and this hospital provision for a country of over two million inhabitants is very inadequate.

the various juntas de beneficencia in 1917) and the most influential (it sends two members to the superior council, whereas the other juntas send but one each). Besides the Hospital de San Juan de Dios, the Santiago board controls eight other hospitals with a total of between three and four

² Cadiz, M., and Edwards, C. R.: *Hospitales Especiales para Infeciosos*, November, 1917, I, 207.

thousand beds, an orphan asylum, an asylum for the insane, and an extensive and important outpatient system, with nine dispensaries attached to hospitals and six operated independently. Two of the large hospitals for children, the Manuel Arriarán and the Roberto del Río, are noticed later on in this review.⁸

One of the first endeavors of the Consejo Superior de Beneficencia Pública was to find out the actual hospital situation of this country. A hospital survey was accordingly made of Valparaíso, which is estimated to have about two hundred thousand inhabitants, and is the city next in size after Santiago. This survey shows five hospitals with a total of 1,343 beds, including beds for aged persons and chronic and infectious cases, under the control of the junta de beneficencia of that city. This is regarded by the author of the survey as a thousand beds short of the needs of the city, which is the most important seaport in Chile and consequently receives through immigration and emigration more than its share of cases of sickness.⁹

Except in Santiago and Valparaíso, the hospitals lack most of the modern facilities for diagnosis and treatment. For instance, it is said that, in a city of twenty thousand inhabitants, the first appendicitis operation was recently performed in the only hospital, which as yet had no operating room.¹⁰ Because the provincial hospitals are without diagnostic laboratories and installations for radiotherapy, mechanotherapy, electrotherapy, etc., well-to-do patients generally go to

lic subscription.¹¹ This puts a heavy strain on the hospital facilities of the capital.

MATERNITY HOSPITALS AND THE TRAINING OF MIDWIVES

Experience in the United States furnishes no grounds for surprise at finding obstetrics a relatively neglected branch in Chile. Taking the country as a whole, the proportion of maternity



Fig. 4. Waiting room of the polyclinic of San Juan de Dios, Valparaíso.

beds to population is 1 to 8,500, and there are groups of three and four provinces each which have not a single maternity hospital among them. Those which do exist are said to have inadequate attending staffs and insufficient facilities for isolating infectious cases, for care of feeble and premature infants, and even for sterilizing water and dressings. Moreover, it is current practice to refuse treatment to a pregnant woman in any other than the obstetric service, and to separate the obstetric from the gynecological service.¹²

Midwives form a recognized part of the staff of maternity hospitals, and one of the complaints against the present maternities is the insufficient number, not only of physicians but also of midwives. A school for midwives (Escuela de Obstetricia y Puericultura para Matronas) is conducted under the auspices of the medical school of the University of Chile, at the Hospital de San Borja, Santiago. The course is two years in length and instruction is free. The requirements for entrance are age over eighteen and under thirty, good health, good moral character, and five years' schooling. Resident and non-resident pupils (called interns and externs) are received. Each province except Santiago and Valparaíso is allotted an internship, and the candidate is re-



Fig. 3. The court and gallery of the building occupied by the Manuel Arriarán children's hospital, Santiago, until the new building is completed.

Santiago for treatment, and charity patients, if their cases are difficult, are sent there at the expense of the local junta de beneficencia or by pub-

⁸ Viel, V. B.: Speech before the Primer Congreso de Beneficencia Pública, October, 1917, I, 133.

⁹ Deformes, E.: El Problema Hospitalario en Valparaíso, September, 1918, II, 201.

¹⁰ Gómez, V.: Plan de Fomento de los Hospitales Departamentales, December, 1917, I, 396.

¹¹ Guzman: Creación de Hospitales, December, 1917, I, 403.

¹² Münkeberg, C., Espie, J. E., and Monti, M. G.: Maternidades y Hospitales, November, 1917, I, 248.

quired to give bonds amounting to 1,000 pesos (about \$360) that she will practice her profession in her home province for three years after graduation. In the four years from 1914 to 1917, inclusive, the school has graduated 110 midwives.¹³

CHILDREN'S HOSPITALS AND CHILD WELFARE

This subject appears to be one of much interest in Chile, if one may judge by the cities of Santi-

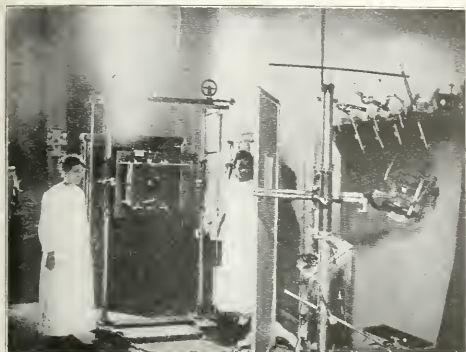


Fig. 5. X-ray room of the polyclinic of San Juan de Dios, Valparaiso.

ago and Valparaiso. The former city has under construction one large hospital of 374 beds for children, the Manuel Arriarán. The accommodations will comprise 162 beds for general internal medicine, 50 for infectious medical and surgical diseases, 116 for general and special surgery, and 46 for nurslings.¹⁴ Plans are shown for enlarging another children's hospital, the Roberto del Rio, to a capacity of 425 beds.¹⁵

Santiago has several societies devoted to child welfare. One, composed of women, the Sociedad Protectora de la Infancia, gives medical and other relief. Another, composed of men, the Patronato del Infancia, maintains a little asylum with fifty beds for mothers and a hundred for infants. Here mothers are received with their infants on discharge from the maternity hospital, cared for temporarily, and helped to make a new start in life; here also are taken children whose mothers are in hospitals.¹⁶ Ten "gouttes de lait" stations (Gotas de Leche) are maintained in Santiago, and the Gota de Leche has been successfully introduced into almost all the cities of the republic. Still another society, the Ollas Infantiles, is undertaking to furnish meals to undernourished school children.

Valparaiso has a private hospital for children,

eighty-five beds for children in the public general hospitals, and an active Sociedad Protectora de la Infancia.¹⁷

OTHER SPECIAL INSTITUTIONS

Tuberculosis Hospitals.—Santiago has one institution devoted to tuberculosis, the Hospital de San José, which in 1916 received 2,744 patients.¹⁸ Valparaiso has two, with a capacity of 218 beds, the Hospital del Salvador, for chronic tuberculosis, and the Sanatorio de Peña Blanca, for curable cases.⁹ Tuberculosis is very general in Chile, and the mortality is high. It is estimated that over 70 per cent of the population is tuberculous, and nearly 29 percent of the deaths in Santiago are due to this disease. Soza¹⁸ believes that 10 percent of the available hospital beds should be devoted to tuberculosis.

Hospitals for Other Communicable Diseases.—Isolation pavilions for the care of communicable



Fig. 6. A pupil in the School for Nurses, Santiago, showing the working uniform (now temporarily discontinued owing to war-time prices of materials) and case for equipment.

diseases are lacking. Vaccination against small-pox is not compulsory in Chile. Infectious diseases contribute largely to the mortality.¹⁹

¹³ Barros, J. R.: La Escuela de Obstetricia y Puericultura para Matronas de la Universidad de Chile, March, 1918, II, 19.

¹⁴ Commentz, A.: El Hospital de Niños Manuel Arriarán, Santiago, September, 1917, I, 14; June, 1918, II, 154.

¹⁵ Jengier, E.: El Hospital de Niños Roberto del Rio, September, 1918, II, 231.

¹⁶ Instituciones Privadas de Beneficencia, September, 1918, II, 328.

Valdés Valdés, I.: El Problema de la Infancia, September, 1918, II, 267.

¹⁷ Lindsay, O.: La Sociedad Protectora de la Infancia de Valparaiso, September, 1918, II, 273.

¹⁸ Soza, E.: Hospitalización de los Tuberculosos, December, 1917, I, 445.

¹⁹ Cadiz, M., and Edwards, C. R.: Hospitales Especiales para Infecciosos, November, 1917, I, 267.

Hospitals for the Insane.—The Casa de Orates de Santiago shelters over 1,900 patients of all classes and grades—acute and chronic, curable and incurable cases, epileptics, idiots, cretins, imbeciles, senile dementals, alcoholics, and criminals. The need of a system of psychiatric hospitals and institutions for different classes of mental disease or defect is emphasized.²⁰

NURSING AND NURSING EDUCATION

The profession of nursing was officially established in Chile through the foundation in June, 1906, of the state school for nurses. The course is two years in length, and includes theoretical work, taken in the morning, and practical work in the hospitals during the afternoon. A uniform, modeled on that used in the United States, had been adopted, but the outbreak of the present war doubled the cost of the materials and caused its discontinuance.²¹

The part played by members of the religious sisterhoods in the conduct of the hospitals makes it necessary that the sisters should understand nursing. Accordingly, in 1917 courses of instruction for the sisters were established in the Santiago hospitals del Salvador, San Borja and San Juan de Dios. In the Hospital de San José, where twenty beds have been set apart for purposes of instruction, the sister superior has endeavored to modify the habit worn by the sisters to make it more suitable for nursing.²²

In general, the cure of the sick would appear to be at least partially in the hands of attendants (*cuidadores, veladores*) whose duties and status are not defined in the sources of information available.

HOSPITAL STANDARDIZATION

Chilean hospital administrators are very eagerly and earnestly seeking standards on which to model the organization and administration of their institutions. The hospital standardization movement in this country is apparently being followed with lively interest in Chile. A rather full abstract of the hospital standardization meeting of the American College of Surgeons appears in the *Revista de Beneficencia Publica*,²³ and the reviewer remarks, "The authoritative pronouncement of the Chicago committee is a powerful reinforcement of our opinions." One characteristic shared by the various writers in the *Revista* seems to be a sincere desire to see their own present hospital situation in the light furnished by

the best achievements of Europe and America. Chile is apparently working out her own hospital problem.

AFTER THE WAR—WHAT?

The Return of the Hero and What It Means—Prospect and Retrospect

In other days, the old soldiers' home was a shelter for the seemingly helpless and a harbor for the inefficient idle. The name itself, says Callie Hull, writing in the *Vocational Summary*, is reminiscent of the beautifully kept roomy house, with its multitude of benches, on which the heroes of the past sat idly all day long, whittling uselessly at broken twigs, poring over the thumb-worn pages of old magazines, or smoking away the hours which hung so heavily on their hands. Evening brought the supper-bell and the long lines of cripples, with empty sleeves, stumping wooden legs, or sightless eyes, who came together at the long table for the common meal. After that, gathering shadows and darkness—and all were off to dreams of days gone by—days when, with strong bodies and active minds, they had faced the world as men, before the sacrifice of hope, home, work, success, and their very all. A place of idleness and inactivity, clouded with the atmosphere of retrospect, filled with the broken bodies and stagnant minds of men who had read over the door at the time of their entrance the fact that their lives had already been lived—that was the old soldiers' home of the days gone by!

The future will not repeat the past. It will be "the home of the soldier" rather than "the soldiers' home." Reconstruction will be individual rather than institutional. To each returning soldier, the nation will extend a cheery welcome, in the assurance that nothing will remain undone to help him find himself and to equip him for a place in the industrial world—a place which will not be donated to him through a sense of gratitude and charity, but one which he will hold by sheer force of his own ability and fitness. After the best of medical attention, training will be given him, either in a new vocation suited to his disability or in more extensive study which will better equip him to resume the old. Workshops will be open for instruction, colleges will offer courses in agriculture, mechanics, engineering, clerical work, etc., and factories will extend a welcome hand in the matter of training. Everywhere the returned soldier will find that the right of way is his.

The future does not face a "home" set apart at a safe distance from the sphere of industrial activity. Rather it sees "homes," scattered about everywhere, in the large cities, the smaller towns, and the broad expanse of farms, just as they were in the days before the call of war had sounded through the land. And to each, in the evening, will return a man who, in spite of physical handicaps, is holding his place in the industrial life of the nation. The fact that a missing limb has been replaced, that an eye no longer sees, or that an ear has been deafened forever will not make any less cheery the welcome which awaits him from the woman at the gate or the child who toddles down the street to meet him. For the bell at evening will call him, not to an institutional board, but to his own table, where he will talk of the things that are, rather than of those that were, and of the work that lies ahead, rather than that which was ended when the war began; and, while his wounded body will bear, perhaps, the scars of battle, his active mind will look, not backward on the remains of a life that has been ended, but forward to the hopes of a life that is still to be lived.

²⁰ del Campo, M.: El Problema de la Hospitalización de los Enajenados, November, 1917, I, 217. Lea-Plaza, H., and Pontecilla, O.: El Problema Nacional de la Hospitalización de los Alienados, November 1917, I, 397.

²¹ Lira, E. D.: La Escuela de Enfermeras de Santiago, June, 1918, II, 126.

²² Carvallo, C. V., and Lira, E. D.: Organización del Servicio Médico Auxiliar, December, 1917, I, 343.

²³ Amunátegui, G.: Normalización de los Hospitales, March, 1918, II, 41.

THE WAR-TIME ECONOMY PROBLEM IN THE HOSPITAL*

Best Results Obtained When Spirit of Patriotism Is Urged Among Employees—Ways of Solving the Labor Problem—Keeping Hospital Up to Full Capacity—Greatest Single Economy—Quantity Buying Unpatriotic

By THOMAS ALAN DEVAN, M.D., ASSISTANT SUPERINTENDENT, PETER BENT BRIGHAM HOSPITAL, BOSTON

THE subject of economy in hospital administration, important at all times, is especially so in war-time. The practice of economy has long been a studied art with hospital superintendents, but the fact that the government has requisitioned labor and supplies on such an extensive scale has made it necessary that the whole field of hospital management be gone over anew with a view to instituting further economies. When some hospital essentials have advanced 200 per cent in price within two years and the former scale of wages has been entirely discarded, it behooves us to attempt to inculcate a habit of economy among all hospital workers.

The campaign for economy, at all times unpopular, is, in these war-time days, less so than formerly. When the plea for economy is put upon a patriotic basis, it is heeded the more readily. The public press has aided greatly in putting people in a frame of mind to listen to arguments for economy. From the standpoint of hospital administration, every means of fostering the patriotic spirit throughout the hospital household should be encouraged. Employees should be urged to invest in Liberty bonds and war saving stamps; the bulletins of the Food Administration should be posted; and short talks to the nurses and help on the scarcity of gauze, thermometers, and crockery should be periodical—all to the end that the war may be made real and personal to each hospital worker. It is in this way that we can make each one interested in the practice of economics. The doctor or nurse will not save gauze unless interested in saving it; the kitchen-men will not save grease unless interested in saving it. When these measures are urged as patriotic duties, they receive greater attention.

The study of economy in war-time is the same elusive study it has always been. It is the same close attention to the labor requirements of a situation, the same exercise of careful judgment in the purchase of supplies, and the same diligent tracing of the course of supplies through the institution that it always has been.

GENERAL HOSPITAL ECONOMIES

1. The labor shortage is outstanding. It is an interesting and significant fact that the hospital

is one of the few organizations all of whose trained and experienced personnel is urgently needed by the war machine. Doctors, nurses, orderlies, pharmacists, technicians, and ambulance drivers—all are war essentials in the military sense. Because of this, very soon after the outbreak of the war, hospitals had to curtail activities wherever possible. One of the first places to feel the pinch was the research laboratory. Research work has necessarily suffered. We all know how much time and money were devoted to research. We also know how much research work was undertaken, which, from the outset, could have only a most remote usefulness. At present, however, little research work is carried on, and none should be sanctioned which has not a fair prospect of useful results, since for no other pieces of research work can the expenditure of time and money be afforded.

Because of the shortage of male help, women have been employed wherever possible. At the Peter Brigham Hospital women are employed to tend the steamtable in the serving room, to operate the utensil-washer in the kitchen, as night cook, as night switchboard operator, as pharmacists, and even as ambulance drivers—all to replace men. One hastens to remark that not all of these represent wage-saving on the part of the hospital, because these women are frequently paid as much as men formerly received, though not as much as men at the present time would have to be paid. But it represents a saving of the manpower of the country by just so much. Some hospitals have found it impossible to obtain ward maids and have been forced to have this work done by the nursing force. We have not been forced to change back to the twelve-hour tour of duty for nurses and are not thinking of doing so. We have admitted to the training school larger classes than in pre-war days, and it is probable that we will have to use senior pupils in increasing numbers as head nurses. The Peter Brigham Hospital has derived slight benefit from women volunteers. We have made use of some volunteer workers in the social service department, in the library, on the wards as nurses' aids, and for short intervals in our pharmacy. But volunteers for war work prefer to get in more direct contact with the military forces than the average hospital can supply.

*Read before the Twentieth Annual Convention of the American Hospital Association, Atlantic City, N. J., Sept. 24-28, 1918.

2. An important general measure of hospital economy is to have the hospital take care of as many patients as it possibly can. While we, as hospital executives, have our attention focused so largely on economical measures of purchasing and conserving supplies, we are likely to lose sight of the fact that a hospital running at half its patient capacity is a ship with its cargo space but half filled. How can this be controlled? Perhaps we cannot expect a full hospital all the time, but we can adopt one or two measures to help keep the beds full. The most important measure is to insist that the admitting officer get into the habit of mind of accepting cases whenever possible. The writer believes that many admitting officers often seek reasons for rejecting patients. The admitting officer must make the family physician and the patient feel that he is cooperating with them to accept the patient and not take the attitude that the doctor much furnish good and sufficient reason why the patient should be accepted. He must not study up technical grounds upon which he can safely reject patients; he must make it his practice to admit whenever possible. If the surgical beds are full and the medical service has empty beds, transfer convalescent surgical patients to medical wards and accept new surgical patients. This will not please the physicians, but they can have small grounds for complaint; for, if they cannot fill their own wards, then these wards must be filled for them.

3. It is recognized that a great deal of time and money is wasted in the way in which patients tour from one hospital to another. A duplication of records and a wastage of x-ray plates and laboratory supplies, to say nothing of the time of the doctors and nurses, always results when a patient goes aimlessly from one hospital to another for the same complaint. Occasionally this is necessary to obtain particular opinions. But is it not our duty to urge the patient to return to the hospital where first treated or to bring a letter from that hospital, stating the reasons why it is desirable that the patient be admitted? If the government were to assume control of hospitals, as has been done in the case of colleges, perhaps this repeating process could be controlled. Indeed, such a sweeping war change would result in many important economies.

4. Shall the hospital, as a matter of war-time economy, do quantity buying in the face of prospective higher prices? This is a question which has been answered in the negative at the Peter Brigham Hospital. It is our general policy not to buy extensively for future needs, because we do not consider it patriotic to do so. Heavy buying tends to produce just the shortage which the

government is striving to avoid. Furthermore, if one buys for future needs, there is practically no point short of the limits of the treasury where he may stop. Every ardent salesman tells us that the commodity in which he is interested is to be advanced in price 10 per cent or 20 per cent next week or next month. As no article, except those the prices of which the government has fixed, is exempt from this upward tendency, there is no limit to the list of articles which we are advised to store away. The two or three exceptions to our general policy have been on butter and eggs. We have put into storage about four months' supply of each of these necessities. After all, should not the hospital stand on its own footing and seek, along with everyone else, its chance of procuring supplies as they are needed? We believe it should. In connection with the question of quantity buying comes that of centralized buying. This has been tried out thoroughly enough through the Hospital Bureau and other agencies to have established its usefulness on a sound basis. Rapidly advancing prices render it especially important and profitable to make use of contract agreements such as these agencies have in force. Moreover, it is a great economy of time, because one knows that the contract price represents the bottom market price. It is a war-time economy to make ever increasing purchases through a centralized agency.

SPECIAL HOSPITAL ECONOMIES

Among the numerous separate items of hospital economy which may be mentioned are the following:

1. In an institution where gauze is "recovered," it is perhaps more economical to purchase a 24-20 grade gauze instead of a lower count, inasmuch as the better gauze at a cent or cent-and-a-half increase in price can be washed perhaps five or six times, while the lighter weight will stand but three washings. Also, on the wards, for extensive urological drainage cases, a Bethune pump is found to save gauze greatly. Paper bandages and absorbent pads, "cellucotton," and sphagnum moss are passably satisfactory as substitutes for gauze and cotton. Where one has access to a good cotton-picking machine, the most economical and satisfactory method of overcoming the cotton shortage is to have old white rags picked over into cotton. At the Peter Brigham Hospital we have had to buy almost no cotton since installing a cotton picker. This picked cotton is very absorbent; in fact, it is so satisfactory as absorbent cotton that the institution now buys no absorbent cotton, so-called. At present we have just about enough white rags to supply our needs as cotton.

2. Our consumption of glycerine has been cut in half by excluding its use from a mouth wash extensively used on the wards and limiting its use in enemas. Similarly, absolute alcohol is no longer used at the Peter Brigham Hospital.

3. When a gas-ether apparatus is used for anesthesia it is important to have some one who will be responsible for seeing that all valves are tight. A leakage here is a leakage in the exchequer.

4. In pre-war times, enamel urinals were not used at the Peter Brigham Hospital. Poor glassware has been the rule for the past year or so, and recently we have installed enamel urinals for all "precaution" cases, as the glass ones would not stand sterilizing without breaking. A considerable saving has resulted.

5. The suggestion is made that, as a matter of hospital economy, two lectures on the costs of hospital supplies be inserted in the curriculum of the training school for nurses.

6. Until recently, bath blankets at the hospital were sent to the laundry after being used once. Now each patient has a set of two bath blankets. These are kept in his bedside table and are changed once a week. This procedure has reduced the number of bath blankets passing through our laundry by 50 percent.

7. Turkish toweling is now purchased by the yard and made up in the sewing room. Allowing for all costs, it is estimated that we save just the difference of one grade of toweling.

8. Perhaps the dietetic department has seen more modifications due to war exigencies than any other. This is doubtless due to our effort to keep up with the regulations of the Food Administration. But these regulations frequently do not point in the direction of economies. Nowadays, however, we find ourselves purchasing oranges of considerably higher counts, veal in larger amounts, cattle of lighter weight, less beef, and prunes of much smaller size, than formerly. Every other week, fish can be served on three, instead of the customary two, days. Tripe, liver and tongue are served more frequently than formerly in an effort to follow the directions of the Food Administration. Merged butter is used at some institutions. We agree with those who believe that coffee can be enhanced in flavor by the addition of a little chicory, and this permits the purchase of a lower-priced but satisfactory coffee. Our very limited experience with egg powders and milk powders has not been encouraging. The labor shortage has brought about the adoption in some hospitals of a cafeteria system of serving nurses and help. A great economy of food and labor is claimed for this system, as well

as a great saving of dishes. In most serving rooms, the employment of war-help has resulted in a greatly increased bill for replacing crockery. At the Peter Brigham Hospital a new dish-washer recently broke \$22 worth of dishes in one week. It is probably poor economy to get a cheap man at this post.

9. In the wards a very appreciable saving of food has resulted from urging the nurse to study carefully the dietetic requirements of her patients and not to serve them twice the amount she knows they will eat. We have observed the shrinkage in our garbage as a result of this measure.

10. It is interesting to note that, in the nation-wide food conservation campaign, so little has been said about the destruction brought about by rats and mice. Yet it is even more important than ever in these days of soaring prices to attack these ever-present pests. In our experience, the careful distribution of poison has been most efficacious. One person should be made strictly accountable for its distribution, care, and final collection.

11. A word about the war-garden. We believe that, unless the hospital has considerable land at its disposal or unless it can make use of patient help, a war-garden is not an economy. All that can be said for it is that it helps to stimulate the habit of economy throughout the hospital and that it fosters the patriotic spirit. As a saving of money, the war garden fails.

12. For one hospital extravagance we have yet to find a good remedy, and that is, prodigality in the use of hot water. Close attention to faucets and the adoption of automatic shut-off valves, such as are in use on some laundry machines, may check a little of the wastage, but how much flows on to the sea! Possibly the hot-water service could be shut off from some buildings for a portion of each day. For the coming winter, in the face of another coal shortage, we should look to economy in electricity as well as in hot-water service. Then too, we must conserve heat. Last winter we closed up a great many doors and windows for the season. It was surprising the number of places we found we could close up without interfering with ventilation. This, together with a "close-the-door" campaign, resulted in a considerable conservation of heat.

13. Probably in these brisk war days, time- and labor-saving machines are especially economical, even though the machines themselves have gone up in price. We have recently installed some additional machines in the laundry. The work of the laundry cannot proceed faster than the capacity of its slowest machine. If there be

a backing up of the work before the extractors or the dryers or the presses, the appropriate remedy is indicated. This sounds simple, but at the Peter Brigham Hospital such a backing up had apparently existed for many months without its becoming known. It is, therefore, the part of economy to see that all the working parts of the laundry are evenly coordinated.

SUMMARY

By way of summary, one can say that war-time economies are pre-war economies intensified. They mean the subordination of all the hospital activities to the chief essential of caring for patients and training nurses. They mean, too, the adoption of broad policies, such as the policy of attempting to make the war real and personal to

each hospital worker in order that he may be interested in economizing; the policy of striving to keep every bed full; the policy of fostering centralized purchasing; and the master policy of eternal vigilance.

Abstract of Discussion

MR. DANIEL D. TEST, Philadelphia: I have called the doctors, the nurses, and the employees together separately, about once in three months, and I have talked over the problems of the cost of material and the very great difficulty that we have in getting money to pay our expenses. The added cooperation even of the cleaners in using soap has been a very large saving, and it has brought about a new spirit of cooperation and loyalty. They like the idea of having the superintendent come and talk to them.

After careful investigation we find that the use of a 24-28 grade of gauze is much more economical than the one that was recommended here, 20-24.

HOSPITAL ACCOUNTING

Detailed Allowances and Expenditures of Departments Shown from Month to Month by Expense Analysis—Value of System in Stopping Leaks—Benefits of the Budget System

BY CHARLES A. PORTER AND HERBERT K. CARTER, OF THE STAFF OF THE MODERN HOSPITAL

[Continued from November issue, p. 375]

EXPENSE ANALYSIS AND BUDGET SYSTEM

EXPENSE ANALYSIS

THE Charge Register shows the departmental expenses in a general way. Headings are given in this book for the principal groups of expenditures, as heretofore explained, so as to facilitate the transfer of the individual expenditures to the Expense Analysis sheets.

The Expense Analysis (Form 22) is for the purpose of showing the detailed allowances and expenditures of the departments in such a manner that comparisons from month to month and for the previous period and year may be made. It also shows how the expenditures of each department are to be distributed.

A sheet is made out for each department as follows:

1. Administration.
2. Wards.
3. Private rooms.
4. Emergency ward.
5. Dispensary.
6. X-ray.
7. Laboratories.
8. Social service.
9. Ambulance.
10. Housekeeping.
11. Steward's department.
12. Laundry.
13. Training school.
14. General house and property.
15. Heat, light, and power.
16. Corporation.

The following examples show in detail how these sheets are made out:

EXPENSE																								
YEAR	1914	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937
ADMINISTRATION																								
WARD																								
PRIVATE ROOM																								
EMERGENCY WARD																								
DISPENSARY																								
X-RAY																								
LABORATORIES																								
SOCIAL SERVICE																								
AMBULANCE																								
HOUSEKEEPING																								
STEWARDS DEPARTMENT																								
LAUNDRY																								
TRAINING SCHOOL																								
GENERAL HOUSE AND PROPERTY																								
HEAT, LIGHT, AND POWER																								
CORPORATION																								

ANALYSIS														
MONTH	1914	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927
ADMINISTRATION														
WARD														
PRIVATE ROOM														
EMERGENCY WARD														
DISPENSARY														
X-RAY														
LABORATORIES														
SOCIAL SERVICE														
AMBULANCE														
HOUSEKEEPING														
STEWARDS DEPARTMENT														
LAUNDRY														
TRAINING SCHOOL														
GENERAL HOUSE AND PROPERTY														
HEAT, LIGHT, AND POWER														
CORPORATION														
TOTAL														
INCREASE														
DECREASE														
REMARKS														

Form 22. Expense Analysis. Above, left-hand page; below, right-hand page; with binding margin to be added at right-hand and left-hand sides respectively. Actual size, 19 $\frac{1}{4}$ by 11 $\frac{1}{2}$ inches.

EXAMPLE No. 1—ADMINISTRATIVE

Item	Appropriation for month	Expense present month	Expense period to date	Expense same period last year
Controllable expense:				
Salaries and wages—				
Superintendent and assistants.....	\$.....	\$.....	\$.....	\$.....
Purchasing agent.....				
Clerks.....				
Supplies—				
Stationery.....	\$.....	\$.....	\$.....	\$.....
Printing.....				
Postage.....				
Miscellaneous.....				
Telephone and telegraph—				
Telephone service.....	\$.....	\$.....	\$.....	\$.....
Operators' salaries.....				
Tolls.....				
Telegraph service.....				
Legal expense.....				
Furniture and fixtures.....				
Miscellaneous expense.....				
Total controllable expense.....	<u>\$.....</u>	<u>\$.....</u>	<u>\$.....</u>	<u>\$.....</u>
Uncontrollable expense:				
Corporation expense.....	\$.....	\$.....	\$.....	\$.....
General house and property.....				
Total.....	<u>\$.....</u>	<u>\$.....</u>	<u>\$.....</u>	<u>\$.....</u>
Charge percentage to wards.....				\$.....
Charge percentage to private rooms.....				
Charge percentage to laundry.....				
Charge percentage to dispensary.....				
Charge percentage to general house and property.....				
Charge percentage to ambulance.....				
Charge percentage to training school.....				
Charge percentage to x-ray.....				
Charge percentage to steward's department.....				
Charge percentage to housekeeping.....				
Charge percentage to emergency ward.....				
Charge percentage to social service.....				
Charge percentage to laboratories.....				
Total (as above).....				<u>\$.....</u>

NOTE.—All of the expenses of the Administrative Department are charged to departments by percentages determined by the Superintendent and his assistants.

EXAMPLE No. 2—WARDS

Item	Appropriation for month	Expense present month	Expense period to date	Expense same period last year
Controllable expense:				
Salaries and wages—				
Head nurses.....	\$.....	\$.....	\$.....	\$.....
Nurses.....				
Dietitian.....				
Etc.....				
Etc.....				
Etc.....				
Supplies—				
Medical.....				
Surgical.....				
Furnishings.....				
Miscellaneous.....				
Total controllable expense.....	<u>\$.....</u>	<u>\$.....</u>	<u>\$.....</u>	<u>\$.....</u>

Uncontrollable expense:

Charge from administration.....	\$.....	\$.....	\$.....	\$.....
Charge from steward's department.....	.....	.....	.....	.....
Charge from housekeeping.....	.....	.....	.....	.....
Charge from general house and property.....	.....	.....	.....	.....
Charge from laboratories.....	.....	.....	.....	.....
Charge from x-ray.....	.....	.....	.....	.....
Charge from laundry.....	.....	.....	.....	.....

Total..... \$..... \$..... \$..... \$.....

Number of patient days treatment..... \$.....

Cost per patient per day.....

Analysis sheets for emergency ward, social service, dispensary, and private rooms are made out in this same way.

EXAMPLE No. 3—X-RAY DEPARTMENT

Item	Appropriation for month	Expense present month	Expense period to date	Expense same period last year
Controllable expense:				
Salary of operator.....	\$.....	\$.....	\$.....	\$.....
Salary of assistants.....				
Supplies:				
Plates.....				
Tubes.....				
Miscellaneous.....				
Total controllable expense.....	\$.....	\$.....	\$.....	\$.....
Uncontrollable expense:				
Charge from administration.....	\$.....	\$.....	\$.....	\$.....
Charge from housekeeping.....				
Charge from general house and property.....				
Total expense.....	\$.....	\$.....	\$.....	\$.....
Charge percentage to wards.....				\$.....
Charge percentage to private rooms.....				
Charge percentage to emergency ward.....				
Charge percentage to dispensary.....				
Total (as above).....				\$.....

The sheets for the laboratories, ambulance, training school, housekeeping, and laundry will be made out very nearly like the above example.

EXAMPLE No. 4—STEWARD'S DEPARTMENT

Item	Appropriation for month	Expense present month	Expense period to date	Expense same period last year
Controllable expense:				
Salaries and wages—				
Salaries for supervision.....	\$.....	\$.....	\$.....	\$.....
Cooks.....				
Scullions.....				
General kitchen help.....				
Miscellaneous.....				
Dairy products—				
Milk.....				
Cream.....				
Buttermilk.....				
Cheese.....				
Eggs.....				
Butter.....				
Meat, poultry, and fish—				
Beef.....				
Mutton.....				
Pork.....				
Ham.....				
Poultry.....				
Game.....				
Fish.....				
Shellfish.....				

Groceries and provisions—				
Flour and cereals.....				
Bread and crackers.....				
Coffee, tea, cocoa, and chocolate.....				
Yeast, baking powder, etc.....				
Confectionery and ice cream.....				
Sugar, molasses, and syrups.....				
Etc.....				
Fruits and vegetables—				
Potatoes.....				
Carrots.....				
Apples.....				
Oranges.....				
Etc.....				
Miscellaneous—				
Ice.....				
Table Water.....				
Coal.....				
Supplies.....				
Repairs.....				
Total controllable expense.....	\$.....	\$.....	\$.....	\$.....
Uncontrollable expense:				
Share of administrative expense.....	\$.....	\$.....	\$.....	\$.....
Share of general house and property.....				
Total expense.....	\$.....	\$.....	\$.....	\$.....
Charge percentage to administration.....				\$.....
Charge percentage to wards.....				
Charge percentage to general house and property.....				
Charge percentage to private rooms.....				
Charge percentage to emergency ward.....				
Charge percentage to dispensary.....				
Charge percentage to social service.....				
Charge percentage to ambulance.....				
Charge percentage to housekeeping.....				
Charge percentage to laundry.....				
Charge percentage to training school.....				
Charge percentage to x-ray.....				
Charge percentage to laboratories.....				
Total (as above).....				\$.....

EXAMPLE No. 5—GENERAL HOUSE AND PROPERTY

Item	Appropriation for month	Expense present month	Expense period to date	Expense same period last year
Controllable expense:				
Salaries and wages—				
Mechanics.....	\$.....	\$.....	\$.....	\$.....
Elevator runners.....				
Etc.....				
Repairs—				
Furniture and fixtures.....				
Elevators.....				
Etc.....				
General supplies.....				
Total controllable expense.....	\$.....	\$.....	\$.....	\$.....
Uncontrollable expense:				
Heat, light, and power.....	\$.....	\$.....	\$.....	\$.....
Charge from administration.....				
Charge from steward's department.....				
Insurance.....				
Taxes.....				
Rent.....				
Miscellaneous.....				
Charge for depreciation.....				
Total expense.....	\$.....	\$.....	\$.....	\$.....

The Expense Analysis gives a comprehensive record of past performances, but this is not sufficient in making up a Budget. There are other factors to be considered. The advance or decline in prices of supplies and material, additions to the institution, or any change of the administra-

In municipal hospitals the Budget system is almost universally used, and, as a rule, they must live within the bounds of their appropriation. Private and quasi-public institutions will find the

[illegible]

Form 24. Superintendent's Monthly Report. Actual size, 12 by 9 inches.

The Budget as shown (Form 23) is designed to present the request for the coming year, the

The summary sheets of the Budget and an example of the sheets from the various departments will be shown in succeeding chapters.

[To be continued.]

LITTLE JOURNEYS TO PLACES AND PEOPLE WORTH KNOWING

**The Sixth Little Journey—To the Nurses' Home of Mount Sinai Hospital, New York
—Every Effort Made to Give the Best of Nursing Education
and Home Life to Pupil Nurses**

BY MARGARET J. ROBINSON, R. N., FIELD EDITOR, THE MODERN HOSPITAL, CHICAGO.

THE standards of Mount Sinai hospital need no description or introduction. The hospital was established in 1852 and at that time had a bed capacity of 28 patients. When its new buildings and various departments are completed it will have a capacity of 750 and will be, with one exception, the largest voluntary hospital in the world.

Nurses in training at Mount Sinai may have contact with ninety thousand patients in a year in the hospital and dispensary services. Over a thousand nurses have graduated from this school. A large percentage of them occupy positions of responsibility in the nursing field. To have graduated from Mount Sinai is a mark of prestige for any young woman in the nursing profession.

The school maintains about two hundred nurses at present and thirty-six supervising graduates, exclusive of those in the social service department. A registry for graduates has over three hundred nurses on its list; more than four thousand calls for their services were received during the year of 1917.

Special arrangements have recently been made whereby women from approved colleges and uni-

versities will receive a credit of nine months on the three years of training in the school. A number of scholarships are awarded to nurses in training. These scholarships include one of \$500 for a course in the department of nursing and health of Columbia University, New York, recently established by the president of the training school, and a number of annual awards of \$100 in gold to students for excellence in scholarship, deportment, and bedside nursing.

These scholarships serve a threefold purpose. In the first place they give, in some cases, an actual financial assistance to ambitious young women who need more funds to carry them through their training; secondly, they are an impulse towards finer scholarship and a greater devotion to detailed practical work in the school, and lastly they encourage more student nurses towards further post graduate nursing education.

There are several other capitalized funds for the use of the school. One, known as the pleasure fund, provides for theater parties and dances in the winter months, and has purchased the best of victrola records. A library fund furnishes newspapers, current magazines, current literature and reference books. A sick nurses' fund sends sick



Fig. 1. Probationers' study hour.



Fig. 2. A class in practical nursing.

and weary nurses for needed rest under proper and happy conditions. One fund provides for the renovation and new and attractive furnishings for the home.

Even the bouquet of orchids and lilies of the valley worn by the superintendent of the training school at commencement time and the violets tied with purple ribbon worn by the graduating class are given by a generous-hearted trustee. Other men from this very human and kindly board of directors and their auxiliaries furnish the big Christmas tree and candy and gifts, and concert and theater tickets and moving picture shows.

The nursing section of the Mount Sinai Base Hospital unit No. 3, now in service in France, was formed in the training school. This unit is complete in its supervision and personnel and was recruited without thought of the sacrifice of the hospital. The staff, hospital, and training school gave their best. On January 15, 1917, there were twenty-one enrolled Red Cross nurses in the list of graduate assistants; sixteen of these were released for army service.

The educational advantages of the school of nursing are as good as can be secured. The hospital fortunately has sufficient funds to meet all the requirements of present day methods of nursing education, an administration which believes thoroughly in advanced nursing education, and a competent force for the supervision and instruction of the training school.

Miss Elizabeth Greener, the principal of the school, has the complete cooperation of the officers of the training school board, and of Dr. S. S. Goldwater, the director of the hospital, in all things which will tend to advance the best methods of nursing education, the health protection and social welfare of the nurses in training.

The training school has scientific and practical laboratories for instruction in pathology, bacteriology, materia medica, and dietetics. There is thorough nursing instruction in medicine, surgery, pediatrics, anatomy, chemistry, nursing ethics, principles and practice, obstetrics and gynecology, special practice and social welfare.

A demonstration room constantly adds to its furnishings and equipment anything and everything necessary to practical and thorough demonstrations in nursing art and practice. This room contains various supply closets, plumbing, beds, and practically all the material needed in daily use for the care of patients. All junior classes of student nurses receive thorough instruction here before they are permitted to take part in the direct care of patients.

To meet the present great need of nurses, as large classes as the school capacity will accommodate are being admitted. In September of this year there were fifty-eight entered, in three sections, in order to avoid the confusion which might occur in the handling of so large a number of probationers at any one time. The first group consists of twenty pupils for the regular three-year

course; all are high-school or college graduates. The second group will be the first section of the Vassar School of Nursing students, twenty in number, all graduates of the college. The third group will be the second section from the Vassar school.

When I visited the nurses' home of the Mount Sinai Hospital I came out into the wide entrance hall just as the night nurses were reporting for duty, all ready to go over to the hospital to take up the work where the day force left it. They were a pretty sight, trim and orderly and cheerful. A little later the day force returned to the home, strolling in by twos and threes, and soon the great cheerful living room at the left of the hall was filled with friendly groups.

The great size of the room and the large number of student nurses in it didn't seem to detract from the homey atmosphere of the place at all. A beautiful picture hung over the wide mantel shelf. On one wall was a tapestry of wonderful weave and coloring; on another were unobtrusive frames holding original letters written in faded brown ink, one a discharge from the army of the United States, signed "George Washington,"

in the midst of it all, girls everywhere, young and pretty and light-hearted, and sedate and studious, all in spotless blue and white. May God love them all and bring them trained hands and heads and luck and happiness!

At the desk in the hall was the house mother, the nurses' chaperon and social companion, a charming gray-haired woman, a graduate nurse, who looked thoroughly the part she was there to play. Behind her was a roster board with colored wooden pegs which showed at a glance where each nurse was at the time. One color meant that the nurse whose name was underneath was on duty in the hospital, a peg of another color showed that she was off duty or on vacation or ill or taking her maternity training in another hospital.

The duties of the house mother are numerous, and all necessary in the scheme of things to protect and mother the girls in the home. She is on duty from six o'clock in the evening until two o'clock in the morning. She greets the day nurses when they come to her desk to change the keys on the roster board. She directs the new arrivals and sees that they are made comfortable. She



Fig. 3. The demonstrating room. Bed-making.

and the other an officer's commission, signed "Abraham Lincoln."

The picture of the room was completed by big comfortable lounging chairs and settees, a grand piano and victrola, soft shaded library lamps, a huge floor rug of vivid coloring, and

gives out the permissions for late leave and checks them when the nurses return to the building.

The house mother receives the visitors, and when ten o'clock comes, arranges for the closing of the house and the noiseless return of those

who have had a good time outside of the building. At eleven o'clock she makes rounds, and knows that each nurse is accounted for, and visits the roof, too, to see her children who are sleeping out of doors. Then she returns to the main floor and

The serving of the night supper is only one of the illustrations of the spirit in which the nurses at Mount Sinai are cared for, and the thoroughness with which everything is planned for their training and comfort.



Fig. 4. A corner of the nurses' home roof.

waits until all the nurses on duty have had their supper.

At two o'clock, if all is well, the house mother goes off to bed, and the night supervisor takes charge and after that the night watchman goes about every so often to see that all the children of the house are safe from harm.

A night housekeeper is on duty in charge of the serving of night suppers to the interns and nurses and employees of the night force. She has to assist her a cook and waitress and a porter.

The night supper served is a real meal and not a light lunch. It consists of hot meat and vegetables and all that goes with them. Things are so arranged that everyone on duty is relieved for this meal. The service begins at 10:30 p. m. Attractive trays are serviced to nurses on duty on isolated cases. Over three hundred nurses of the school and fifty to eighty special nurses are served in the dining room during the twenty-four hours. The dining room is cheerful and well cared for. On the side walls the brackets with electric candle fixtures have yellow silk shades on them, which soften and mellow the general effect.

The officers, the directors, and administrators of the Mount Sinai Hospital are of a race which as a rule does things well. Their hospitals in this country, wherever you find them, from San Francisco to New York and from Canada to the Gulf, are efficiently managed and stand distinct among themselves for a broad charity. To these men the home is part of their splendid religion. To them the education, the happiness and protection of the young girls in training are vital things. They are worthy of their trust.

Eugenics in Brazil

There is a eugenic society in the enterprising city of Sao Paulo, the first to be organized in that country. The object is frankly to improve the race and render it worthy of so grand a country. The subjects to be covered in this connection are the laws of heredity, the propagation of knowledge of eugenics and hygiene and the spread of education in general. This plan of instruction aims to inform the public as to the harm wrought by syphilis, alcoholism, tuberculosis, etc. Other activities are regulation of prostitution, prenuptial examination, and all steps which will diminish the birth rate of degenerates, idiots, etc. It is to be hoped that this patriotic movement will be taken up by other Brazilian states.—Brazil-Medico.

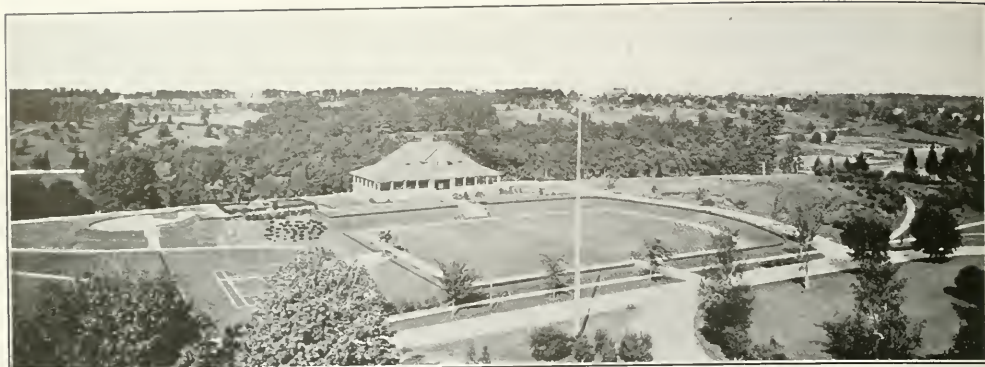


Fig. 1. Recreation hall of Sheppard and Enoch Pratt Hospital.

FROM OUR FIELD EDITORS' NOTEBOOKS

Two Mental Hospitals Where Occupational and Diversional Therapy Are Used—Study of Diversional Therapy at Sheppard and Enoch Pratt Hospital—Wide Variety of Occupations at Kalamazoo State Hospital

Sheppard and Enoch Pratt Hospital, Towson, Baltimore

There are few hospitals which enjoy a more beautiful situation than Sheppard and Enoch Pratt. The buildings, scattered over the extensive grounds on the wooded hills just outside of Baltimore, have more the aspect of a country estate than that of an institution for the care of the mentally disordered. As in many public parks, the trees and shrubs bear labels on which are printed plainly, in each case, the common and botanical name. This work, however, was done, not by the gardeners, but by a patient, who, though ignorant of botany when she took up the task as a labor of love, has herself gained mentally and physically and has also added to the pleasure of other patients.

Dr. Edward N. Brush, the superintendent, is a strong believer in the therapeutic value of occupation in mental disorders, and a wide variety of handicrafts are practiced by the patients for their value in diversional therapy. Dr. William Rush Dunton, Jr., assistant physician at Sheppard and Enoch Pratt, is known to all who are inter-

ested in occupational therapy, through his publications on the subject and his activity in the National Society for the Promotion of Occupational Therapy. The telephone operator at Sheppard and Enoch Pratt, by the way, is a blind girl, who is said to perform her duties very acceptably. The switchboard work of an institution is said to be very suitable for the blind, who are subject to fewer distractions than workers who can see.

Dr. Brush has promised *THE MODERN HOSPITAL* an article on the work which can be done by an endowed hospital for mental patients in moderate circumstances.

The Kalamazoo State Hospital (Mental)

The industrial reeducation and instruction in the arts and crafts in the Kalamazoo State Hospital, Kalamazoo, Mich., show very definitely the therapeutic value of these methods in the care of the mentally ill, and, although the work is always considered primarily for its therapeutic value, it has proved to be one of the greatest factors in the efficiency and the economic administration of this state institution.



Fig. 2. Another view of the recreation hall (in the foreground, to the right), with the superintendent's residence in the distance (center), and the women's building at the left.

The patients are carefully and scientifically graded, both as to their previous social and industrial condition and as to their mental and physical capacity. They are given something to do, something to think about, and, if their cases are capable of improvement, their minds are led, as a child's would be led, from the kindergarten to a higher grade, and then still higher, until at last they may gradually find themselves again.

Women patients who were so low in the mental scale that they had to be shown how to braid rags in order to learn to braid their own hair have been patiently and gradually taught to make beautiful things that any of us would be glad to have in our homes, with the result that both their mental and physical strength has grown while they were doing it.

Reclamation is considered everywhere in the industrial building, and nothing is wasted that can be used again. Hats for the patients and the employees who do the farm work are made here, from the unraveled straw matting which comes around chests of tea. Socks which refuse further mending when they come from the laundry are unraveled and woven into socks again.

Old clothes, beyond all hope of mending and repair, are cut up into rags and woven into attractive and durable rugs. The benches on which the workers sit while weaving are made by other patients in the carpenter shop. The two hundred and eighty-five rugs needed to furnish



Fig. 4. The Kalamazoo State Hospital, with some of the working patients in the foreground.

In the upholstery department are made all the mattresses used in the hospital, and chairs and couches are upholstered. Part of these rooms are given over to looms which weave canvas and a very good grade of linen toweling, made from the flax which is also spooled here.

Solid and artistic chairs and tables for use in the institution and all furniture repairs are made in the cabinet maker's room, and cane seating done. The patient who is most expert in caning learned the trade here.

In the cannery, where a machine makes the tin cans used, are put up the fruits and vegetables grown by the

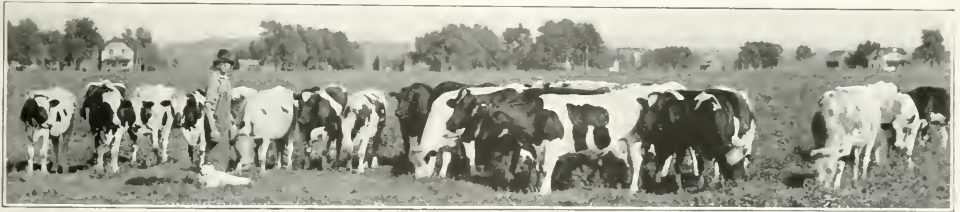


Fig. 3. A dairy worker and some of his animals.

the new building added to the hospital for attendants' quarters have all been made in the weaving room.

Laundry bags are woven, fish-net fashion, out of heavy cord. Waste burlap which comes into the storerooms around bags and packing cases is woven into brown rugs, and decorated with artistic designs by using thrums, the mixed wool waste of different colors which is sorted out into the separate colors, spooled, and woven into the rugs by the patient students. The thrums are used, too, for warp and woof. On Donegal looms they make really beautiful window curtains and draperies for use in the hospital buildings, the kind that would cost a goodly sum.

In another room a number of women patients were running motor sewing machines and making their own aprons and dresses. Some were able to sew only the straight seams, but there were others who had advanced far enough to cut and fit the clothing. The pieces of the blankets destroyed by excited patients are quilted together and covered with canvas. This makes an indestructible blanket to use for violent cases.

In the shoeshop, new shoes are made and the shoes worn by patients and employees are kept in order as long as they are worth saving. A master-tailor supervises the work done in the tailor shop, and this is one place in the industrial building where some trade knowledge on the part of the patient is an absolute necessity; men who have had no previous experience can do only the very simplest work here.

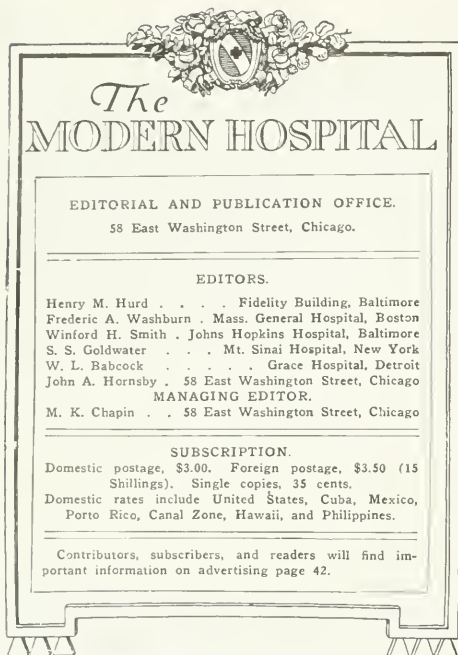
farmer patients. In this way the patients and employees may have better grade of canned goods and more of them than the institution could otherwise afford to give them.

The hospital has its own farm and its own dairy, and under the supervision of a skilled farmer and a skilled dairyman, the work is all done by the patients who are best suited by experience, or who need out-of-doors work, and great improvement has resulted.

The end-results of the industrial reeducation show 33 percent of improvement in patients who can undertake the work and 22 percent discharged from the care of the hospital.



Fig. 5. Laying pavement at the Kalamazoo State Hospital.



Our Opportunity in Belgium

If the nations to which remains only the breath of life in a few broken or starving bodies can spend that breath in giving thanks for deliverance, what should be the thanksgiving of this nation—still rich, powerful, unscathed by the horrors of invasion, and lightly touched by the suffering and loss of war? Should it not take the form of a thank-offering? We owe to those countries that bore the brunt of the war a debt which it will take us long to repay. Particularly do we owe an immeasurable debt to the little nation whose epic stand held back the German war machine for six fateful weeks and saved the day for Western civilization.

"What can America do after the war by way of beginning to pay the debt of gratitude she

A Merry Christmas? The blood-stained page has too lately closed. Except to children and the thoughtless, merriment will return but slowly. A joyful Christmas—the most memorable the world has known for many centuries—this we can celebrate with thankful hearts before we turn our faces toward the New Year and the beginning of that future which we have glimpsed hitherto only through rifts in the battle smoke—that future whose significance it will take us perhaps years to grasp. The new day means the realization of some of humanity's age-long dreams—it does not mean the pleasant ease of old. Courage, ardor, vision, and self-denial—if we needed these in the dreadful times that are past, we shall need them ten-fold more in the soul-searching times before us. If you will have a wassail toast, let it be: To the great days to come! May we rise to their measure!

owes Belgium?" This question was addressed by a member of the staff of this magazine to Captain Dr. René Sand, official delegate from Belgium to the meeting of the American Medical Association last summer. When Captain Sand's reply was published in *THE MODERN HOSPITAL* only two months ago¹ one scarcely dared to think of the time when we might claim the privilege of helping Belgium—after the war.

"The first few months of peace," wrote Captain Sand, "will decide our future fate; either we shall slip down to haphazard ways and hasty, patched-up solutions, or we shall rise to a system of competence, efficiency and constructive reform. At that moment our convalescent nation will need material help, personal help—nurses, social workers—and advice. . . .

"We could imagine no greater service to our country and no better way of perpetuating the brotherhood which has grown up between both nations than a permanent American foundation in Belgium. Its triple purpose would be to foster research, to offer information on reconstruction problems, and to maintain an educational campaign aimed at raising the standards of life in Belgium."

As Captain Sand points out, ravaged Belgium has yet a rare—perhaps a unique—opportunity—the opportunity to make a fresh start. Rightly used, this means possibly the achievement of progress that might have been unattainable on the basis of the past. For the United States to

be invited to participate in this fruitful experiment is a high honor. Is it not also a great privilege for the hospital profession to do its share—which should be an important one—in the working out of this great idea? What pride and satisfaction might we not feel in seeing Belgium the experiment station of civilization—the seed plot wherein an opportunity for germination might be afforded to promising reforms which find no room to unfold in the overgrown soil of other countries! Would not this be a

¹Sand, René: How America May Help Belgium After the War, October, 1918, XI, 256.

magnificent opportunity to make health what it should be, the cornerstone of the social edifice, and to build a hospital system from which should radiate enlightenment and health education for the people? We could scarcely ask a greater privilege than to be associated in such a work.

How could this be accomplished? That is for Belgium to tell us. The first step which THE MODERN HOSPITAL would like to see taken would be the formation of an American commission to study the Belgian situation and to learn the needs and aspirations of the Belgians. The members of the commission should be practical men—and women—for it must not be forgotten that, in a country which has lost so many of its men, women must perforce play an important part in reconstruction. They should be practical people, we have said, realizing meanwhile that he who is called the dreamer may be the most practical man, and that among the most practical qualities for a commission of this kind are sympathy, tact, constructive imagination, and infinite patience with and interest in the problems which its members are to study. It is not time yet for organizers and administrators; indeed, the best administrators in the world might be the worst possible choice for such work. This is a task which calls for the open mind rather than the practised hand.

If the idea is once given responsible sanction and entrusted to suitable commissioners to carry out, opportunity should be afforded to the American people to contribute toward the expense of its fulfillment. It should be the pleasure, as well as the duty, of every American citizen to give for this purpose according to his means. We should be not merely paying a portion of our debt, but also taking advantage of a golden opportunity to do constructive work which, in the end, would surely be for the benefit of the whole world, ourselves included.

Some Advantages of Institutional Membership*

When the new plan of organization for the American Hospital Association was discussed at the Atlantic City meeting, it became evident that its advantages required some explanation. "I am a member of the association," said one and another superintendent in effect; "when I attend its meetings, I represent my institution; when I go home, I give my hospital the benefit of what I have learned during the sessions. What do we gain by acquiring institutional membership?" Possibly there was even a positive misunderstanding—a feeling that institutional membership was

a device to get more from the hospitals, rather than a means whereby the American Hospital Association might render its members more efficient service. The suggestion that hospitals would find it to their own advantage to take out institutional membership even seemed to arouse a certain resentment, the impression evidently being that this advantage would be secured only by discriminating against those hospitals which had not institutional membership. It is therefore worth while to study carefully the actual bearings of the plan.

Institutional membership is going to put the association in a position to render services worth many times the institutional membership fee—services which the hospitals need now and are going to need more and more as time goes on. The weight and authority of the association will be increased, and it will be able to exert greater influence before state and national legislative bodies, if it can display credentials as the official representative of the hospitals, its constituent members, than if it appears merely as an association of individuals connected in various capacities with the hospitals. Now, in the reconstruction times ahead of us, the financial and other interests of the hospitals are going to constitute a serious problem, demanding study of the incidence of taxation and of legislation affecting hospital welfare from other points of view. An officially accredited spokesman will be able to command consideration and avert ill-considered legislation which might prove disastrous to the hospitals.

If the hospitals come to the support of the plan, the proceeds from the institutional membership fee, wisely used, will enable the association to give the smallest of its constituent members expert service the cost of which would be prohibitive to the individual hospital. The benefits of this expert service will accrue proportionately more to the small, weak institution than to one that is large and prosperous. Let us suppose, for instance, that the increased revenue from institutional membership fees permits the association to engage, on annual retainers, high-grade legal counsel, an equally high-grade hospital consultant, and a publicity expert. Then, if a hospital at Jenkins Four Corners or Last Chance wishes to know its liabilities under the terms of a contract or its rights as a beneficiary of a will, it will have the right, as a constituent member, to bring the problem before the association and to receive an authoritative opinion, the monetary value of which may be many times the cost of institutional membership. Again, the same hospital has perhaps been running behind in spite of the best ef-

*The Bulletin of the American Hospital Association, page 472, further describes the institutional membership plan, and page 71 of the advertisement section contains an application blank.

forts of the superintendent and staff. An expert opinion is needed as to the treatment necessary to put it on its feet. A competent hospital consultant would charge \$100 a day and expenses. The Jenkins Four Corners hospital can not pay anything like that sum. Application to the American Hospital Association, however, brings out the possibility of having the association's hospital consultant make a tour of inspection of the Jenkins Four Corners hospital and four or five others on the same route, at a cost to each hospital only of its proportionate share of the consultant's traveling expenses. Let us further suppose that one of the hospital consultant's findings is that the community does not understand the hospital or the service the hospital is prepared to render, and hence does not support it. A publicity campaign is indicated. The superintendent's training qualifies her to run the hospital, but not to advertise it. Professional "promoters" are costly and of dubious value. The American Hospital Association, however, will furnish, without cost, attractive publicity material, prepared by its publicity expert for use in local newspapers. Or, if it is desirable to base a publicity campaign on the local situation, the association's publicity expert will plan such a campaign at nominal cost.

These are merely a few illustrations of the otherwise unattainable benefits which hospitals might secure through a properly financed association. Others will readily suggest themselves—a laboratory for testing hospital supplies, an information exchange, etc. Experience will suggest many other ways of effective cooperation through the medium of the reorganized association.

How many of these benefits will accrue to the hospital world at large, without distinction of membership? A great many of them; certainly there should be no attempt to confine them to members by discrimination against non-members. The association is bound to lose the very weight and influence which constitute the chief reason for institutional membership if it allows itself to become the representative, not of American hospitals as a whole, but merely of hospitals which see fit to pay ten, twenty-five, or fifty dollars for their respective institutional memberships. Rather, it should be the effort of the association to work for the good of the hospitals without regard to membership—to make non-member hospitals feel that the American Hospital Association is their friend, with their interests at heart.

What, then, are the inducements to institutional membership? Why should not a hospital remain an outsider if it can, without paying a membership fee, derive many of the benefits from

the reorganized association? That difficulty, we believe, will take care of itself. Hospitals will naturally be reluctant to ask the help of the association on their individual problems unless they are making the association some return for the service. When the value of the service is far in excess of the membership fee, it will be strange if many hospital boards hesitate after having the advantages of membership pointed out to them.

Finally, the individual hospitals are going to profit greatly by the increased attention to hospital affairs which institutional membership will demand of hospital boards, and the consequent promotion among trustees of interest in and knowledge of the principles which should guide hospitals and the standards by which they should be judged. Today, too often boards of trustees have no clear idea of the work and needs of the institutions with which they are connected or of their own relations with these institutions. One board may consider its duties ended with the raising of money for ends of which it has no clear conception; another may, through motives of mistaken economy, hamper the most valuable activities of the institution; and a third may interfere disastrously with the superintendent's management. Trustees may approve or disapprove the work of the superintendent without having any true criterion for such judgment. Institutional membership should be the means of bringing boards of trustees into closer relationship with their respective hospitals, so that they may be prepared to cooperate more efficiently and intelligently with the superintendents. It should become general practice for trustees, as well as for superintendents, to inform themselves of the trend of hospital progress by attending the meetings of the American Hospital Association. These trustees are generally able, progressive business men, who need only an insight into hospital principles to become most valuable aids to hospital progress. With their interest thoroughly aroused, the success of the American Hospital Association and of the individual hospitals is assured.

The War Industries Board and Hospital Supplies

We are requested by the section on medical industry of the War Industries Board to give publicity to several announcements which are of interest to hospitals.

It is suggested that the prospects for securing needed surgical supplies are now very much improved if the hospitals place their orders through the usual channels. For the guidance of the government, hospitals and physicians are urged to fill

out and return to the board inventories of their probable needs for the next six months, with indications of the articles that are difficult for them to secure.

The United States Railroad Administration has suggested that, in order to avoid congestion of transportation during the winter, hospitals assemble their supplies as early as possible. If any freight agent questions a hospital's right to have needed articles shipped, his attention should be called to circular C. S. I-A issued by the car service section, division of transportation, United States Railroad Administration, dated March 26, 1918. The present embargo by the American Railway Express Company is confined to shipments weighing five hundred pounds or more. If an express shipment of more than five hundred pounds which is desired for emergency purposes should be refused by the express company, statement of the fact should be made to Lieut.-Col. F. F. Simpson, chief of the section of medical industry of the War Industries Board. An effort will thereon be made to adjust matters satisfactorily.

The platinum section and the section of medical industry of the War Industries Board express appreciation of the hearty response made by physicians, dentists, and others to the call for scrap platinum. The governmental demand for platinum for making of explosives has been tremendously decreased in accordance with the curtailment of war activities, and it is therefore requested that no further scrap platinum be tendered to the government.

The Hospitals of Chile

Chilean hospitals became part of a unified system somewhat less than a year ago, and Chile seems in a fair way to work out a national hospital policy. This achievement is apparently the natural result of conditions widely different from any with which we are familiar. A country with a property-owning class, small but dominant, by virtue of intelligence and education, over a large, illiterate, and hopelessly indigent laboring class, naturally tends toward centralization. Add to this the fact that our neighbor to the south has but a single religious denomination to reckon with, and one may begin to appreciate some of the reasons for unfamiliar phenomena.

Chilean medical and hospital men are citizens of the world—eager and interested students of the progress of events in Europe and America. Their familiarity with people and institutions in the United States is rather surprising. The proceedings of the American Hospital Association, the American Medical Association and the American

College of Surgeons are cited by writers in the official organ of the central council which controls the Chilean hospitals; the book by Hornsby and Schmidt on "The Modern Hospital" and the articles on the community hospital by Miss Barrett and Miss Jordan, published in this journal, are quoted as authoritative; and the Mayo Clinic, the Massachusetts General Hospital, the Ohio Valley General Hospital, Mount Sinai Hospital of New York, the new Bethany of Kansas City, and the Robert Packer of Sayre, Pa., are mentioned as exemplary.¹

As will be seen by the article on the Chilean hospital system which appears on another page², these Chilean writers are keen critics of their own hospitals, which they do not hesitate to judge by the standards of the most advanced institutions elsewhere. (It is interesting to note, by the way, that when it comes to institutions for the insane, they find the most recent and the most advanced example of the agricultural colony for incurables, not in Europe or America, but in Buenos Aires, Argentina, which has a large and well-organized "Open-Door" colony.)³

Their criticisms, however, are not destructive or pessimistic. Every review of existing conditions is followed by practical suggestions for improvement. The pages of the *Revista de Beneficencia Publica* abound with outlines for model hospitals of fifty or a hundred beds, plans for the organization of dispensaries and outpatient services, plans for the organization of first-aid services in small cities, etc. The Chileans are convinced that the health conditions in their country form a serious obstacle to its progress; hence the energy with which they are addressing themselves to the solution of these problems. Centralization has its advantages as well as its disadvantages, and it may very well be that Chile will furnish some very interesting developments in the organization of hospitals and public health work.

Our Relations with Latin America

One of the duties which the United States must prepare to assume after the war is that of developing our natural relationships with the rest of the world and particularly with our neighbors in the Americas. We have not yet entirely freed ourselves from a certain provincial—not to say parochial—self-centeredness, which we must shake off if we are to play our allotted part in the reconstruction of the world after the war.

¹ Guzman, A.: Creación de Hospitales, Rev. de Benef. Pub., December, 1917, I, 403.

² Chapin, M. K.: The Hospitals and the Hospital System of Chile, p. 438. ³ del Campo, M.: El Problema de la Hospitalización de los Enajenados, Rev. de Benef. Pub., November, 1917, I, 317. Lea-Plaza, H., and Fortecilla, O.: El Problema Nacional de la Hospitalización de los Alienados, *ibid.*, 327.

We know too little about other countries—and particularly, about South and Central America. We have much to learn and not a little to teach. Are we ready to set about both tasks now that peace is here?

This question is addressed particularly to hospital people. As remarked in the preceding editorial, the hospitals of Chile (and probably the same thing applies to most of the other South American countries) are ready and eager for the best in ideas and products that Europe and North America have to offer. It is for us to realize that they have much to offer us in return. A civilization longer established on American soil than our own, of independent development, and heir to a civilization that is still older, must have much of interest and value for us. If our attitude toward our Latin American neighbors has ever been one of provincial condescension, we cannot too quickly realize its inappropriateness. The various American countries, already connected by many bonds of common interest, have certain joint health problems to work out together—for instance, the problem of international quarantine, discussed in this journal some years ago.¹ Without doubt, the experience of South and Central America will be of great value.

Hospital people in the United States have already developed cordial cooperative relations with Canada. Canadian hospital men and women are active and interested members of the American Hospital Association. Is it not time that the association signalized its interest in the rest of the Americas by holding a Pan-American meeting, which representative hospital and public health officers from South and Central America and Mexico should be invited to attend, for the purpose of explaining the desires and points of view of their respective countries? And should it not be the privilege and the duty of our most progressive hospitals to throw open their doors to Latin American physicians and nurses who desire to learn what we can teach of hospital administration and training school methods? Should we not collect more first-hand information with regard to medical, hospital, and nursing conditions in the countries to the south of us?

These are but a few of the angles from which this subject opens up vast possibilities. Are we to make the most of this great opportunity to knit our continent together? Or are we to let it slip by and see the rest of America looking, as of old, to Europe for inspiration and leadership? We can not too soon begin to consider this matter seriously.

Hospital Service in Rural Communities

A most interesting and suggestive "Preliminary Report on Hospital Service in Rural Communities" has been prepared by the department of surveys and exhibits of the International Health Board of the Rockefeller Foundation. It is based on the 1890 morbidity statistics of the United States Bureau of the Census, on figures collected by the Metropolitan Life Insurance Company in surveys covering over thirteen thousand cases of sickness among a total population of over six hundred thousand, and on data collected by the State Charities Aid Association in 1913, through intensive surveys in Dutchess County, New York, covering an aggregate population of nearly twelve thousand and total cases of sickness numbering sixteen hundred.

The study indicates that the general sickness rate of the country, both rural and urban, is about 20.8 per thousand population, but that the rural rate somewhat exceeds the urban. No attempt is made to estimate in terms of money the economic loss occasioned by sickness among the employed population, but it is computed that, in the state of North Carolina alone, over six million working days are lost by the male population and considerably over seven million by the female population. The average duration of sickness among the general population, including wage-earners, is found to be from six to twelve days a year, and from one-eighth to one-twelfth of a given group of wage-earners are every year disabled for work because of sickness.

The number of physicians available for care of the sick is much larger in the United States than in Europe. The population for each physician in this country is 582, a proportion which is approached nowhere in Europe. In the European countries tabulated, the proportion ranges from one physician for each 1,475 in Scotland, to one for each 7,865 in the [erstwhile] Russian Empire. The number of physicians in this country, contrary to general opinion, has increased but little in proportion to the population. There has, however, been an increase in the demand for medical service, owing to the broadening of the medical field and increase of intelligent public interest in the subject. There are only about half as many physicians to a given population in the country as in the city, the rural south having the poorest medical service.

In the field covered by the surveys of the Metropolitan Life Insurance Company 27.2 percent of the sick received no medical care whatever; 2 percent received dispensary care; 9.8 percent were cared for in hospitals; and 61 percent were cared for at home. Approximately the same pro-

¹ Plea for a Constructive Pan-American Quarantine, *THE MODERN HOSPITAL*, August, 1914, III, 106.

portion is presented by the figures of the State Charities Aid Association. Another unfortunate fact developed by the survey of the latter organization is that 40 percent of the sick did not receive adequate care. Nearly half of those cared for at home, and 20 per cent of those cared for in hospitals had inadequate care, the insufficiency of hospital care being due chiefly to lack of social service and follow-up work.

Possibly the most important divisions of the study are those devoted to "Some Things That Need to be Known to Solve the Hospital Problem," and "How Some of the Information Needed to Solve the Community Hospital Problem May be Secured." "A hospital is not a thing of a day. It is intended to endure through many years and even generations." In working out an adequate hospital program, therefore, it is necessary that many things bearing on local conditions and the future general trend of sickness be known—death rate, wealth of population, increase or decrease in population of area to be served, social conditions, percentage of foreign group, character of industries and industrial diseases, prevailing type of general diseases, etc. Means by which fundamental data on these subjects may be collected are suggested, including study of the experience of existing community hospitals, experiment in the construction of typical community hospitals through which a close study of community health conditions might be made, and community surveys carried on through rural home visiting nurses, who possess peculiar facilities for gathering information, particularly on the point of the proportion of cases that can be cared for at home and in the hospital.

We wish that these excellent suggestions might be put into effect. The way to construct a hospital program is from the ground up, not from the steeple down—in other words, by a careful and intensive study of community conditions as a preliminary to any plans for hospital construction or organization. The principle advanced in this report that the hospital problem is merely one branch of the general problem of organizing the community for the conservation of health and the cure of disease, moreover, is surely a sound one. One of the most important pieces of work that we can imagine would be a survey of health needs and resources of the country sufficiently comprehensive to serve as a basis for a working program including the organization of health associations, visiting nursing services, dispensaries, group diagnostic centers, and hospitals. We hope that the "Survey of Hospital Service in Rural Communities" is but the preface to a wider and more thorough survey of the general problem.

The Death of F. S. Bunn

The American hospital profession has sustained a severe loss in the death, on November 3, of F. S. Bunn, of Youngstown, Ohio. For the past ten years Mr. Bunn had been superintendent of the Youngstown City Hospital, which, under his management and largely owing to his untiring devotion and exceptional executive ability, attained a high standing among the hospitals of the country. As a personal friend has said, "He was a man who did his very best and knew well how to make successes out of the commonplace things." The manner of his death, as well as his life, attested to his unpretentious heroism. He died of an attack of influenza, culminating in pneumonia; and the fatal issue is ascribed by Mr. Bunn's asso-



F. S. BUNN.

ciates to overfatigue due to his efforts in combating the epidemic, as well as to the fact that he insisted that the limited supply of anti-influenza serum available at the hospital be used to inoculate all the nurses before he would consent to receive a dose himself.

Names of Hospitals Employing the Eight-Hour Day Desired

THE MODERN HOSPITAL would like to have the names of all institutions in which the eight-hour day has been introduced. Any remarks as to the results of the change will also be of interest. The courtesy of those sending in information will be greatly appreciated.

Four things come not back: the spoken word; the sped arrow; time past; the neglected opportunity.—Omar Ibn Al Halif.

HEALTH INSURANCE AND ITS RELATION TO HOSPITALS*

Favorable Conclusions with Regard to Health Insurance— Opportunity for Hospitals to Become Hub of System—Advantages to Be Received

By THOMAS HOWELL, M.D., Superintendent New York Hospital,
New York City

In presenting this report to the American Hospital Association, your committee on social insurance believes that it will render greatest service if it confines its discussion to the place of hospitals in a system of health insurance. Sociologic aspects of the plan are only of general interest to a hospital association and, except as they indirectly concern us, may very properly be entrusted to the official state commissions which are making exhaustive investigations of health insurance in relation to public policy.

Simultaneously with the work of the health insurance commissions, some of the best medical talent of the country has been devoting careful thought to the problem and, from various angles, has reached conclusions favorable to health insurance. It is notable that the reasons given by several of the prominent leaders in American medicine for favoring health insurance relate to the development of the much needed spirit of cooperation and coordination in medical service. Dr. Alexander Lambert, president-elect of the American Medical Association, favors health insurance because it "offers the very scheme through which medicine is developing and through which it is bound to develop to the highest degree in the near future—that of group medicine."

Dr. Andrew R. Warner, superintendent of Lakeside Hospital, Cleveland, Ohio, also believes that individualistic practice of medicine must go, and prophesies that "health insurance will do much to bring the day when we must have something better."

Dr. B. S. Warren of the United States Public Health Service makes the further suggestion that "under health insurance the medical profession, in its efforts toward preventive medicine, will also receive outside aid," and cites foreign experience to show that health insurance will bring cooperation from "the public, the employers, and the employees, and will give to each a continuous stimulus for the prevention of sickness among the wage-earning population."

Others welcome health insurance because it will bridge the gap between the medical profession and many data now inaccessible. Dr. S. S. Goldwater, director of Mount Sinai Hospital, New York, one of the most earnest students of health insurance, says he favors "compulsory health insurance, because industrial conditions which are inimical to health can be most readily disclosed and most effectively dealt with under a scheme of health administration in which the insured workers are grouped mainly according to occupation."

Dr. Richard Cabot looks to health insurance for "an improvement in the treatment of wage-earners by private physicians because their diagnosis will be checked up by some one and because any check is better than none."

Perhaps none of these endorsements of health insurance will carry so much weight with medical men as the report of the British Medical Association, coming from a democratic country where health insurance has been actually tried out. The British Association sent a questionnaire

to its members asking for criticism of the act and suggestions. They summarize their returns as follows:

"The degree of unanimity so far disclosed is somewhat remarkable. On a subject which five years ago was the most highly controversial that had ever been before the profession and which still, in some places, and everywhere in some of its aspects, excites argument, it is found (1) that many matters which at the beginning of the controversy gave rise to most apprehension have assumed a position of quite minor importance; (2) that the general system by which the state provides medical advice and treatment under the insurance scheme is in the main approved, and that criticisms have a tendency to concentrate on a comparatively few points which, though of great importance and indeed vital to smooth working, are, after all, matters of detail which ought to be capable of adjustment; (3) that there is a large body of opinion in favor of the extension of the health insurance system, both to kinds of treatment not at present provided for and to classes of persons at present excluded therefrom."

Without question, the war has given great impetus to health measures. Conservation of human life is no longer a luxury. It is an essential. The medical profession has risen to the emergency and has made significant contributions to the science of army sanitation and surgery. Reports from the War Department show that the physical fitness of the military forces is being maintained at a most gratifying standard and that there have been important achievements in the surgical and hospital care of men disabled in battle.

Conservation of civilian life is a close second in importance. What is being done for the military army should stimulate national interest in the adoption of health insurance laws to protect the industrial army upon which we must depend for munitions, ships and supplies. As the official commission on health insurance in New Jersey said in its unanimous report to Governor Edge, who approved its findings:

"We are told that the work of at least five persons in the industries is needed to sustain one man in the trenches. Many thousands, unaccustomed to peculiar occupational dangers, are entering industry for the first time. Women, with their greater susceptibility to sickness and with maternity functions to be considered, are now called into industry in rapidly increasing numbers. Increased use of unfamiliar trade poisons and the rapid expansion of industries are augmenting health hazards. The stress of industry in war is making increasing demands upon physical endurance. . . . As never before, we need now to conserve, for present and future generations, the health and physical vigor of our people. Furthermore, it is the duty of statesmanship to look beyond our immediately pressing needs to the period of reconstruction at the close of the war. We cannot afford to disregard the protective legislative inducements already offered to workmen by our keenest commercial competitors in Europe."

The Pennsylvania health insurance commission, also, in its preliminary report recently made public, makes the statement:

"In the present crisis, if ever, maximum output is imperative, and maximum output depends very largely on the efficiency of the individual worker. . . . If we are to equip and supply our army and feed our Allies and ourselves, and if we are to be ready for the great era of reconstruction which will follow the war, 100 percent efficiency for these workers at home must be our goal."

Health insurance as usually proposed includes cash benefits to make good the wage loss, and medical and hospital benefits to restore health. Compensation for wage loss is indispensable but, as Mr. Lapp, the director of investigations for the Ohio Commission, has ably pointed out, "the restoration of the physical man to working power must be the primary object" of health insurance. In restoration it can scarcely be questioned that hospital service will play a large part. Indeed, it is scarcely exaggeration to say that, if the hospitals are alive to their

* This paper was prepared as a report to the committee on health insurance of the American Hospital Association, to be read at the Twentieth Annual Convention, but, owing to Dr. Howell's inability to attend, it was read by title only.

opportunity, they should develop into the hub of the health insurance system. Considering the inspiring possibilities, it is nothing short of amazing that comparatively little attention has heretofore been paid to the place of the hospital in the health insurance plan.

Perhaps we are at fault. Some years ago Dr. Goldwater gave warning of what was to come, but we did not bestir ourselves. At that time he said:

"Workmen's compensation is just the beginning of the great movement that will result in the establishment here of sickness insurance of the kind already in existence abroad. . . . If there is ever to be a sickness insurance scheme . . . the beneficiaries of that scheme should be placed in a position where they will get the service required as part of the workings of the system itself, which means that the voluntary hospitals and dispensaries . . . must be incorporated into or affiliated with the system and not needlessly and expensively duplicated by the state."

Health insurance offers positive advantages to hospitals in increased revenues, wider fields for research, and immediate contact with all who need hospital care.

At the New York Hospital, which is located in an industrial district, we recognized early that proper handling of workmen's compensation cases would mean a substantial increase in our receipts. Our annual receipts from this source at the Fifteenth-Sixteenth Street Hospital, exclusive of fees turned over to our attending surgeons, were \$15,065 in 1915 and \$16,474 in 1917. Health insurance will have an even more marked effect on receipts. A large percentage of both hospital and dispensary free patients will automatically become pay patients. Of over two million days of treatment given by forty-six hospitals associated with the United Hospital Fund during the year 1913-1914, 60 percent were wholly free. Of 166,000 patients treated by hospitals reporting to the Pennsylvania State Board of Charities, 159,000 were either free or partly free, and over 800,000 dispensary patients paid in little more than \$60,000. At the New York Hospital it was found that 79 percent of ward patients and 95 percent of dispensary patients would come under health insurance as pay patients. The probabilities are that these percentages are somewhat higher than would obtain in hospitals situated in non-industrial districts. They serve to suggest, however, the large possibilities for increased revenue under health insurance and tempt one to speculate in glowing terms of paid staffs and supplementary equipment!

The preliminary report of the Pennsylvania Health Insurance Commission states that "sixteen of the sixty-seven counties in Pennsylvania, some of them at considerable distances from better-supplied areas, have no hospital beds whatever and nine other counties have less than one per thousand population. For the entire state on the basis of the estimated population for 1918, they found the number of beds per 1,000 population to be only 2.9—scarcely more than half the generally accepted standard.

In California in 1917, where the official health insurance commission reported a need for 10,000 beds for wage-earners, 8,621 of the 11,066 beds were in private hospitals, most of which were beyond the means of wage-earners. Of the remaining 2,445 beds, a large number were in institutions rated "unsatisfactory" by the State Board of Charities.

In the Dutchess County, New York, survey of sickness, it was found that hospital treatment was secured by only 10 percent of the total 1,600 patients, whereas investigation showed that 28 percent of the cases could have been adequately cared for only in a hospital. In other words, nearly two-thirds of those who needed hospital care did not receive it.

It is worth noting here that the objection raised to health insurance by the secretary of the Associated Merchants and Manufacturers of New York State related to the cost. Necessary care under health insurance, he declared, perhaps without very careful computation, would require the expenditure of \$100,000,000 more for hospitals alone to equip New York for this service. Members of our association scarcely need to be reminded that, despite an inadequate supply of hospital facilities to meet the needs of our population, under present conditions we have more hospitals than we can adequately support. The interests of the community are served better by a small number of well-supported hospitals than by a large number of impoverished ones. Until funds are available, hospital facilities should not be extended.

It is here that we may hope from health insurance a double-barrelled benefaction. Not only will the majority of our free patients become pay patients, and the majority of those at present unable to secure any hospital care whatsoever be enabled to become patients on a paying basis, but the hospitals will thereby be given funds with which to undertake long desired improvement and expansion.

This is all predicated on the assumption that we include hospital care in our health insurance plan. One of the great defects of the English law is that it makes no provision for hospital care. Accordingly, the hospitals are worse off than they were under old conditions. It seems hardly probable that we will repeat such a blunder. In fact, the development of adequate hospital facilities for wage-earners and their families, now so frequently forced into destitution by sickness, is one of the most beneficent features of universal health insurance as now proposed in many of the states.

Not only will health insurance supply funds with which to improve and expand hospital service, but it will measurably facilitate medical science. Automatically it will bring under hospital supervision larger numbers of patients from whom to deduce scientific observations. It is to be presumed that, within the scope of health insurance, all who need hospital care will demand it and that the prestige of the health insurance funds may be counted on to overcome certain prejudices against hospitals.

Health insurance will also have the welcome effect of bringing patients under hospital care with less of the delay which is now often fatal. It has been asserted that the average workman has not a single week's wages saved for the proverbial rainy day. Losing more than a few days' time is a serious matter for him. Accordingly, he does not surrender to sickness until he is actually compelled to do so. When he is furnished protection by means of health insurance, it is not so probable that he will hesitate to seek proper attention. Again, it seems safe to assume that the local funds will encourage early treatment to secure speedy restoration to health. How much this means will be seen when we consider how early contact with a disease facilitates the work of the physician.

Health insurance is not visionary. In the words of Col. Winford Smith, health insurance "will surely be with us before many years." It is for us to insist that the important function of the hospital be recognized. We must participate with employers and employees in the shaping of health insurance laws and in their administration after passage. Failure to do this in the case of workmen's compensation led to some unsatisfactory experiences which need not be repeated under health insurance if we do our duty. It is to our interest, in the best sense of the word, to lend our professional aid to the proper

working out of legislation that will meet the need of health conservation and sickness prevention in industrial communities. The health insurance system must be so organized as to offer to the hospital the fullest possible opportunity for useful development and expansion. Routine work should be left to general practitioners. Difficult or obscure cases should be sent to the hospitals. The hospitals, largely relieved of routine cases, will then be able to develop group medicine of a high order.

THE MEMOIRS OF A HEAD NURSE

VI. The Color Line—How a Southern Gentleman and a Camp Meeting Song Pacified Two Bad Niggers

Once in a while, up in the emergency department, we had a case brought in that was pretty hard to handle—for instance, the woman of the streets who had taken bichloride and fought like a tiger when we tried to pump out her stomach, and the Slav woman who wouldn't let us set her little boy's broken leg. But, as Mr. Kipling says, "that's another story."

One day the ambulance elevator came up with what sounded like a decided row going on on board. Two policemen brought out what they would call down south, a black man and a "yaller gal," the colored folks down there being known as "black niggers," "yaller niggers," and "white niggers," according to their tones and shades of complexion. Although these shades might vary in degree from the color of teakwood or mahogany to hand-polished walnut, birdseye maple or white enamel, they would still be niggers. The man was bleeding from several head and facial wounds; in fact, a portion of his scalp was scraping acquaintance with his nose, and his left eyelid was decidedly off the track it usually occupied. The girl was endeavoring to wrap up a badly slashed arm and hand in her petticoat, and both of them were putting up a pretty stiff fight. The air was blue with choice gutter talk; but, mumbled slowly in the soft southern negro dialect, it somehow seemed to lose its coarseness and sounded like the back talk of the end man at a minstrel show.

After considerable struggling, the pair were taken into the dressing room. The man was put on the table and the girl seated in a chair by the window. I tried to take the history required by the hospital and began with the girl.

"What's your name, and where do you live?"

"It doan' make no difference where ah live, case ah aint neber dar 'cept when ahm home, and ah aint neber home, an mah name's mah own biness, an ah aint goin' ter hab no doctors puttin' no crazy patchwork stitches in mah hide, ner no starched nurses askin' foolish questions, an' you all better look out fo' dat boy, he's a bad nigger. He's got de razor in his boot what he used fo' to carve me. It ain't got de bleed wiped off yet. An', lady, I'se a bad nigger, too."

This didn't look very promising. One of the interns, who had been trying, with the help of the two policemen, to examine the man's wounds, heard the girl say "razor in his boot," and made a "bee-line" for the door.

"Good night," he said, "I'm not going to risk any razor cuts in my anatomy, thank you. You officers had better take these people to the jug, where they belong."

It seemed too bad to let them go without something being done for them, so I said, "Wait a minute, I'll go find Dr. Beauregarde. You know, he is a southerner, and maybe he can handle these people better than we can. We should at least get some dressings on them before sending them out again." Then I called for Dr. Beauregarde,

one of the senior interns, and he came up, a big, good-looking chap, with snapping black eyes and a typical southern drawl. He sauntered in leisurely, as usual, smoking a cigarette.

"What kin ah do fo' you, little fo'lady of the cuttin' and tailorin' department?" he asked.

"Please, Dr. Beauregarde," I said, "these colored people won't let us examine their razor cuts or even tell us their names or addresses, and I hate to send them out again without doing something for them."

He motioned me to follow him with the history slip and, going over to the girl, said, "Nigger, what's yo' name?"

The girl answered meekly, "Elizer Jackson, boss."

"Oh, yes," I said, "E-l-i-z-a, Eliza."

"No, mam," said the yellow girl, "L-i-z-e-r, Elizer."

"And what's the black boy's name?" Dr. Beauregarde asked again.

And she answered, "Stoneall Jackson, dey jes calls him Stone fo' short."

In the meantime Dr. Beauregarde was scrubbing up preparatory to doing the necessary repair job on Stone, and the other intern was sewing together the slashes on Elizer's arm. She was, by this time, getting the secondary effects of the cheap whiskey with which she had filled herself before the fray, as well as of the hypodermic which one of the nurses had given to her under protest, and was in a tearful and religious mood.

Each time the sharp, curved surgeon's needle went through her dark skin she prayed, "Lord have mercy, Jesus have mercy," and both she and Stone had changed their gutter accent to a soft "Yeah, Massa," and a "Yeah, Missus" that sounded as if it was straight from a Mississippi river plantation rather than from the district of our big city where even the policemen were afraid to go alone at night.

Poor "Stone" was really suffering a lot, and Dr. Beauregarde, working slowly while he waited for the hypodermic and the local anesthetic to relieve his patient, started humming an old camp meeting song. Soon, from her chair, "Elizer" joined in with the rich contralto obbligato that comes naturally to the negro women, and, to our astonishment, Stone, from the head of the table, while his scalp was being patched together, began crooning a high nasal falsetto of strangely beautiful sound, almost like the twang of a ukelele, the whole blending in a primitive harmony that only the southern American negro knows how to produce.

This is what they were singing:

"Lovin' brother, the worl's on fiah

Doan' yo wan' God's bosom ter be yo pillow?

Doan' yer wan' ter lean on de Rock of Ages?

De Rock of Ages, cleft fo' me—"

The song had as many verses as you had relatives and continued with variations in the obbligato and falsetto to include lovin' brother and sister and mother and father until the relationship was completely exhausted, when it started on "lovin' brother" again. It was sung in 4-4 time and with a peculiar accent on the first beat of each measure.

By the time the song was finished and had reached all around the family and come back to lovin' brother again, Stone and Elizer were all repaired. We sent them to the wards for a few days to heal and heard later from Dr. Beauregarde, who had made them his especial charges, that he had discovered Elizer's grandmother and great-grandmother had been born on a Beauregarde plantation on a Louisiana bayou, and that he had successfully pleaded with the police court judge to let Stone and Elizer off, on a promise to be good.

DETAILS OF HOSPITAL CONSTRUCTION*

**Hospital Construction Necessarily Specialized to Meet
Hospital Needs—Some Details of Construc-
tion Which Are Important in Any
Type of Hospital**

By N. V. PERRY, Constructing Engineer, United States Public Health Service

While this paper is primarily intended to treat certain details of hospital construction developed by years of experience, study, and experimentation, I also desire to mention a few things not directly connected with these details.

War conditions have placed upon the government unusual and, of course, unforeseen demands for emergency hospital accommodations in which the Public Health Service alone has embarked upon a building program involving the expenditure of millions of dollars for hospital construction, much of which will necessarily be of a war emergency nature. For this purpose it has standardized certain hospital units affording the facilities most in demand in Public Service hospitals, and, while most of these buildings are of a temporary nature, it is essential to convenient and economical operation to introduce, wherever practicable, modern and up-to-date facilities.

Floor plans and details of construction of some of these buildings are shown in the accompanying illustrations for your general information and will give an idea of some of the details of construction to be mentioned later on in this paper. The buildings in plan show the proper coordination of facilities required by the Public Health Service in the care and treatment of its patients, consisting chiefly of the discharged personnel of the army and navy, who are beneficiaries of the War Risk Insurance Bureau under the Treasury Department, the sick of the merchant marine, and the injured civil employees of the government entitled to treatment under the provisions of the Employees Compensation Act.

Public Service hospitals differ in many respects from general hospitals where male and female patients are received, and from the older types of marine hospitals, due partly to the introduction of female nurses and to the treatment of diseases which, as an outgrowth of war conditions, demand extensive attention. They should not, therefore, be critically compared with the modern general hospital. They do, however, present some very good features which perhaps might be incorporated in a more permanent type of hospital, and if their exhibition throws new light, either on combinations of accommodations or details of construction, their presence here will be amply justified.

The Public Health Service constantly receives letters from various sections of the country, asking for information relative to proper design and management of hospitals adapted to almost every phase of hospital work for state, municipal, and private ownership, and is making an earnest effort to supply helpful information along these lines, the direction and scope of which are shown by Fig. 1.

The Surgeon General has now undertaken the establishment of a Division of Hospital Information for the collection, classification, and dissemination of information relating to hospital construction, equipment, management, etc., which shall have for its chief end the standardization of hospitals and shall make possible a more uniform system of management. The need of such a division has long been felt, and it is believed the Surgeon Gen-

eral's efforts in this direction will command the hearty cooperation of the American Hospital Association and the medical profession generally.

In securing such information, the Surgeon General will, of necessity, be obliged to depend on the very hearty and painstaking cooperation of various hospital and medical associations throughout the country, for in order to do this most wisely and effectively, it is important to supplement its knowledge of government hospitals with accurate information as to facilities and accommodations supplied in civil and other hospitals, for whatever purpose required. It must study the construction, equipment, and management of hospitals both large and small, particularly those located in sections of the country where climatic and local environment create conditions peculiar to themselves, all of which must be thoroughly analyzed if helpful data are to be secured and intelligent conclusions arrived at.

The Federal government has many millions of dollars invested in hospitals for the use of the Public Health Service alone, which are in many respects peculiar to themselves in that they have been designed almost exclusively for the reception of soldiers and seamen. At the time of their construction they were thought to be, and no doubt were, as well adapted for their purpose as could be devised; but the very rapid progress in medicine and surgery has rendered many of the requirements of even five years ago obsolete, and has made necessary expensive alterations, modifications, or additions to these plants in order to keep them even reasonably in line with modern hospital practice.

While there is no doubt that the future will see many more innovations, it is believed that from carefully compiled records of hospital practice and facilities, gathered from a broad field, it will be possible to say definitely what will best meet almost any given set of conditions in hospital design or arrangement, and so to coordinate each function and facility into a complete plant which will be so well-adapted for the purpose for which it is created that the future will see comparatively little need of expensive remodeling to keep them abreast the progress of medicine and surgery. It is also presumed the same will be equally true in regard to their management and operation, and results that will set new records in accomplishment, efficiency, and economy may be looked for in both of these directions.

Hospital requirements of today are as highly specialized as is the medical profession itself, some catering to one branch, some to another—and still others to all branches—of the medical profession.

If efficiency and economy is the end sought in building a hospital for either general or specific treatment of patients, it is of the utmost importance that the designer should have an intimate knowledge not only of building construction, but also of the various activities peculiar to the particular types of treatment involved, as well as the proper coordination of facilities and accommodations that will best suit the requirements to which the hospital will be devoted, for the reason that the arrangement and grouping of facilities which might be ideal for a general hospital would not be at all suitable for one specializing on tuberculosis, psychiatry, etc., as each has peculiarities requiring facilities and grouping of accommodations peculiar to itself.

While there are many architects in this country who specialize on hospital construction and who have broad experience and opportunities for extended study, yet it is safe to say that the majority of the hospitals built today are the product of local architects, who, at best,

*Read before the Twentieth Annual Convention of the American Hospital Association, Atlantic City, N. J., Sept. 24-28, 1918.

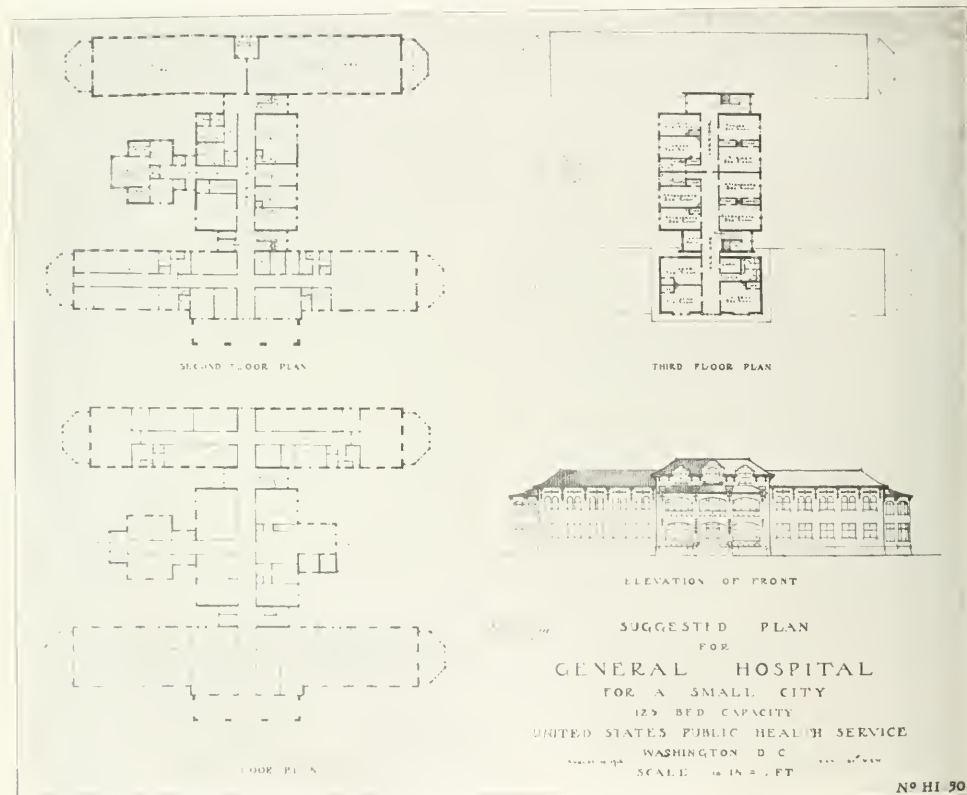
translate into plans the ideas of local physicians and surgeons, supplemented by such knowledge as may be gained in visiting one or several nearby plants, with the result that there are many hospitals which do not prove to be economical or particularly adapted to the needs for which they were created, and which cannot be said to represent the best practice in hospital design.

While many of the government, state, municipal, and private hospitals throughout the country are ideally arranged, comparatively few of them show evidence of a knowledge or careful study of those details of construc-

convenience, cleanliness, comfort, and efficiency of the hospital without regard to their relative importance. They are: ward and operating room lighting, decoration, general heating equipment, and floor construction.

WARD LIGHTING

In connection with ward lighting, it must be admitted that there are many forms of lighting equipment specially designed for this purpose, some good, some indifferent, and some bad, each of which is found in use. The general practice in our later type of marine hos-



NO HI 30

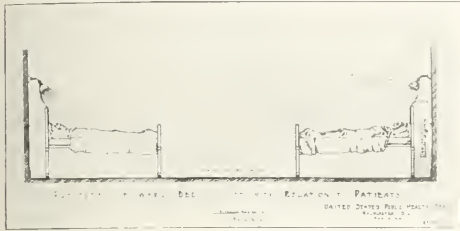
tion which enhance the convenience, operation, and cleanliness of the facilities affected.

Hospital planning involves the supply of accommodations for the treatment of various diseases, each having peculiarities of its own, of which the physician and surgeon has a definite knowledge. The coordination of these accommodations and their grouping into a harmonious whole, however, requires that the architect also have an intimate knowledge of the activities peculiar to each set, their proper relation to each other, and a knowledge of those details of construction best adapted to serve each unit, in addition to building construction, if the hospital when completed is to be satisfactory.

While time will not permit lengthy discussion along the lines of hospital designing, I desire to discuss a few of the many details of construction which add greatly to the

pitals provides for general ward lighting and indirect ceiling fixtures, with large and small lamp on separate switches. The small lamps, to be used at night, furnish a dim light, but sufficient to see that all is well without disturbing the sleep of patients. The larger are used for general illumination at other times. Wall lights are also provided, one over each bed, for local use. These latter are so placed as to be conveniently operated by the patients, and so shaded that the rays fall over the bed area only, but in such a way that the patient whose bed is lighted cannot look directly at the lamp while lying in any normal position and is totally out of the range of vision from adjoining beds (Fig. 2). These wall fixtures are wired on a separate circuit and are operated by the patient under regulations prescribed by the hospital. They also cooperate with the bedside call

system to indicate the bed from which the call originated. For illuminating operating tables, the Public Health Service has adopted the cluster system with specially constructed reflectors which focus the light rays over the entire table area (Fig. 3). The lights are wired on two circuits from entirely separate cabinets in order to

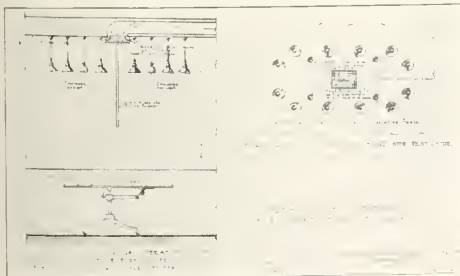


reduce to a minimum the danger incident to a burned-out fuse. Piping for incandescent gas lights is also installed, as a further precaution. The illuminating unit is ventilated to carry off the heat generated by the lights, which adds materially to the comfort of the room. Wall outlets are provided for attaching portable, operating-room-light fixtures or other electrical appliances.

Another important item is the decoration of the various rooms, and the materials to be used for that purpose. The scheme of decoration should depend largely on the illumination both natural and artificial, and the end sought should be to create cheerful surroundings for patients, with color effects best adapted to purely professional activities, such as operating, x-ray rooms, laboratories, dark rooms, etc. A standard color scheme has been devised for all hospitals of the Public Health Service, and a special mixture of paint specified, both of which have proven exceptionally satisfactory and efficient.

HEATING

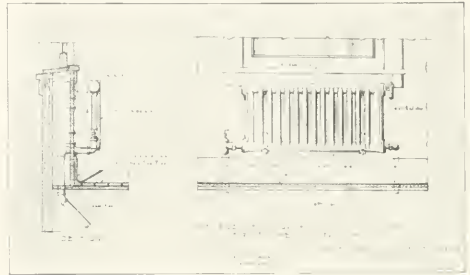
The most objectionable feature of hospital heating in general practice is that of heating with return pipes for radiators passing through the floor so close to wall as to make it inconvenient, if not impossible, to clean the floors and baseboard around them thoroughly (Fig. 4). This has been obviated by the arrangement for the temporary wood frame buildings being constructed as a war



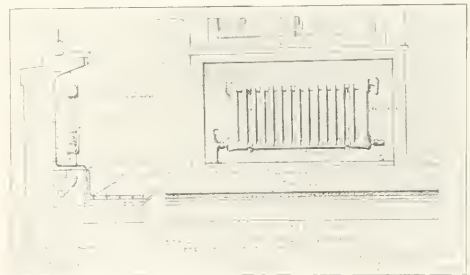
measure, and Fig. 5 shows the arrangement for those of permanent construction. You will notice that there are no pipes passing through the floors. Obstructions for cleaning have thus been avoided, a neater appearance of the rooms obtained, and, in the permanent buildings, much floor space saved without in the least affecting the efficiency of the heating system.

FLOORS

There is perhaps no detail of hospital construction more important than the composition and care of its floors. Based on careful and extended study of flooring of various materials, the following conclusions are arrived at: Non-absorbent materials such as marble, terrazzo, germanic tile, etc., are ideal for all baseboards, and certain floors such as public rooms, halls, operating and surgical dressing rooms, laboratories, x-ray rooms, sterilizing and toilet and service rooms (the latter term being used to indicate kitchens, dining rooms, diet rooms, etc.). Plastic floors have been widely experimented with

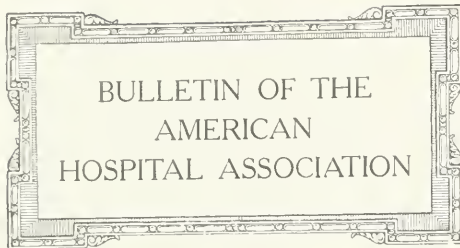


and have been found satisfactory for baseboards and certain other purposes, if properly constructed. Pressed cork tile makes an ideal floor for certain rooms, but for wards nothing has been found superior to a well-laid rift hard pine floor, which, when finished in its natural color and properly smoothed, treated, and waxed, presents a very attractive appearance, wears well, and is easy under foot. Cork tile also makes a very satisfactory floor, but is very expensive in cost and too somber in color for cheerful effect. Linoleums over wood or other material make a pleasant floor to walk on, but it is very difficult to keep the joints tight together, or the strips



tight to the floor over an area of any considerable size, though for runways, in halls and in the aisles in the center of wards, it is very attractive and useful, particularly when let in flush with the surrounding floors, as will be noted in Fig. 4.

In closing, let me say that the Public Health Service has considerable data on these and many other subjects, which it will be glad to supply upon request. The Surgeon General will also appreciate contributions in connection with hospital construction, care, and management, which when received will be carefully analyzed, filed, and made available to those desiring such information.



Offices
728 Seventeenth Street, Washington, D. C.
308 Anisfield Building, Cleveland, Ohio
Monthly Bulletin issued from the Executive Office,
308 Anisfield Building, Cleveland, Ohio
HOWELL WRIGHT, Executive Secretary

Officers		Board of Trustees	
Dr. Andrew R. Warner, President		Dr. Andrew R. Warner, Chairman	
Mr. Joseph B. Howland, 1st Vice President		Mr. Asa Bacon	
Mr. A. B. Tipping, 2nd Vice President		Mr. Richard P. Borden	
Sister Imenia, R.N., 3rd Vice President		Miss Mary L. Keith, R.N.	
Mr. Howell Wright, Executive Secretary		Dr. Robert J. Wilson	
Mr. Asa Bacon, Treasurer		Mr. Howell Wright, Secretary	

Institutional Membership

To the Trustees and Managers of American and Canadian Hospitals:

The American Hospital Association at its last convention became a real association of hospitals with the institutions themselves as the constituent members. Every hospital and institution for giving medical service should at once complete its membership. The importance and need of nation-wide hospital organization was never so apparent as today.

Our hospitals have become more than a charity or a means of giving medical and nursing care to the sick; they have become educational institutions, training men and women for many fields of usefulness; they have become institutions to promote social welfare; they have become important factors in the broad movement to lessen human suffering and loss, the movement often called "Public Health," which is rapidly gaining impetus and importance. It is the duty of every institution to crowd forward to the extreme of usefulness and the front rank of progress. To this end, universal and general thought and deliberations upon common problems, common work and common aims are essential, and isolation under the wisest of local boards of trustees or managers is a handicap upon service and progress.

Hospitals are now making their place in the institutional organization of society—with border lines all around their field of work. There are necessarily many disputed points and there must be ways of organization, procedure and relations with other institutions which are better than other ways. Concerted action is necessary to determine and fix anything.

It is the plan of the American Hospital Association to organize hospitals into one homogeneous force which can be used to promote progress in the work of the institutions and protect the past accomplishments and positions attained. It is the purpose to form a body which can speak for hospitals with all the power the institutions can assemble. The need of such has been demonstrated many times by legislation which has failed utterly to consider the viewpoint or the possibilities of hospitals, although the work of hospitals was a most important factor in carrying out the purpose of the law. The need is also demonstrated in many other ways.

There is every reason to believe that there will come to hospitals the same benefits which have come to every other industry, principle, or purpose which has united all in a common work or of a common mind into one force, acting in harmony, with a dignified and definite means of expression. There is every reason to believe that the new organization will bring to the individual hospital workers more benefits than the old.

For the AMERICAN HOSPITAL ASSOCIATION,

ANDREW R. WARNER,
President.

Plans for making institutional membership effective in the association are now being carried out. With the thought that the hospitals now represented in the asso-

ciation will be among the first to make application for this new membership, return postal cards have been mailed to them. The only information desired through the use of these cards at this time is the name of the hospital, the name of the president of the board of trustees and his address for purposes of correspondence. It is realized that some hospitals—municipal, county and other types—are not governed by a board of trustees. In such instances, as indicated on the card, the name and address of the department head or other official to whom communications about institutional membership should be addressed is requested. A prompt response to these communications is asked. As fast as replies are received, a letter addressed to the president of the board of trustees or other official, signed by the president of the association, will be mailed with an application blank to each hospital. A number of informal applications for institutional membership have already been received. All applications will be placed by the secretary in the hands of the membership committee which has just been appointed by the president as follows: Dr. John M. Peters, Superintendent Rhode Island Hospital, Providence, Rhode Island; Mr. H. E. Webster, Superintendent Royal Victoria Hospital, Montreal, Canada; Rev. Maurice F. Griffin, St. Elizabeth's Hospital, Youngstown, Ohio.

Application Blanks

Institutional membership application blanks have been printed and are being mailed to hospitals. Application for institutional membership must be made on these blanks only. The old form of application for personal membership will be continued for the present.

A copy of the institutional membership blank is printed below. It gives a general idea of the form of application and the nature of the preliminary data required for the consideration of the membership committee. It is printed only for purposes of information. It cannot be used as an application blank. A blank form to be used for this purpose will be found on advertising page 71.

COPY OF

THE AMERICAN HOSPITAL ASSOCIATION INSTITUTIONAL MEMBERSHIP APPLICATION BLANK

Date.....

Note—(This application must be signed by the President of the Board of Trustees or other official representing the governing body of the hospital. The rest of the blank should be filled in by the Superintendent, who should sign his or her name in the space provided.)

To the Executive Secretary,
American Hospital Association,
308 Anisfield Building,
Cleveland, Ohio.

.....being an institution duly qualified
(Name of hospital or dispensary)
for institutional membership in the American Hospital Association, hereby makes application for such membership in the Association and submits the necessary preliminary data for consideration to the Membership Committee.

Check for \$..... in payment of the amount required by the Constitution for initiation fee is enclosed, the same to be returned if application for membership is rejected.

.....
(Signature of President of Board of Trustees or other official representing the governing body of the Hospital.)

.....
(Address for correspondence.)

(See opposite side for initiation fee, membership dues, and other information relative to Institutional membership contained in the constitution and by-laws.)

PRELIMINARY DATA FOR CONSIDERATION OF THE MEMBERSHIP COMMITTEE
Classification of Hospital

Organization
Governmental (Federal, State, County or Municipal).....
Religious?.....Church affiliated with?.....

Incorporated for profit? Incorporated not for profit?
 Private? When established? When and where incorporated?
 Type of Hospital Work
 (Please indicate whether General.....Children's.....
 Maternity..... Tuberculosis..... Contagious.....
 Other special
 Total number of beds in hospital.....
 Out-patient Work
 Do you conduct a free dispensary? Do you conduct pay
 clinics? Do you send physicians from your dispensary
 to treat patients in their homes?

REPORT OF WORK DONE LAST FISCAL YEAR

	No. of Patients	No. of days Treatment
Hospital Patients		
Pay patients		
Part-pay patients		
Free patients		
Public charges		
(Accepted by county, city or township)		
Totals		

Pay patients are those for whom at least the cost of their care is paid.
 Part-pay patients are those for whom only part of the cost of their care is paid.

Free patients are those for whose care nothing is paid.
 (This classification was adopted by the American Hospital Association at its 19th Annual Convention.)

No. of visits to dispensary..... No. of visits to pay clinics.....
 No. of visits made by physicians from your dispensary to patients in
 their homes.....

EDUCATIONAL ACTIVITIES

Medical Education

Does your hospital have university or medical school connections?.....
 If so, what connections and with what university of medical school?.....
 No. of interns..... Duration of service.....
 Do you have resident physicians and surgeons supervising the work
 of interns?..... No.....

Nurse Education

Have you a nurses' training school?.....No. of years of course
 Minimum entrance requirements.....
 No. of pupil nurses..... No. of graduate nurses employed in
 hospital..... Is your training school recognized by the
 state?..... Name of Supt. of Nurses.....
 Other educational activities
 Training of dietitians.....
 Training of anaesthetists.....

(Name of Superintendent)

Date received
 Date referred to Membership Committee.....
 Action of Membership Committee.....
 Membership Committee

DR. JOHN M. PETERS, Supt. Rhode Island Hospital, Providence, R. I.
 MR. H. E. WEBSTER, Supt. Royal Victoria Hospital, Montreal, Canada.
 REV. MAURICE F. GRIFFIN, St. Elizabeth's Hospital, Youngstown, Ohio.

Constitution and By-Laws American Hospital Association

(AS ADOPTED AT THE ANNUAL CONVENTION, SEPT. 26TH, 1918, ATLANTIC
 CITY, N. J.)

ARTICLE I

The name of this Association shall be "The American Hospital
 Association."

ARTICLE II

The object of this Association shall be, to promote the welfare of the
 people so far as it may be done by the institution, care and management
 of hospitals and dispensaries with efficiency and economy, to aid in
 procuring the cooperation of all organizations with aims and objects
 similar to those of this Association; and in general, to do all things
 which may best promote hospital efficiency.

ARTICLE III

Section 1. The membership of this Association shall be—
 A. Institutional.

Any corporation or association organized for the promotion of public
 health or for the care or treatment of the sick or injured shall be
 entitled to membership subject to the following:

Applications for institutional membership shall be addressed to the
 Executive Secretary in writing, signed by a duly authorized repre-
 sentative of the corporation or association; they shall be referred to
 the Membership Committee and the applicant shall become a member
 upon receiving the approval of the majority of the Membership
 Committee and upon the payment of the initiation fees as follows:
 Hospitals with a capacity of less than 100 beds shall pay ten dollars;

those from 100-250 beds, inclusive, shall pay twenty dollars; all over
 250 beds shall pay thirty dollars; all other organizations eligible to
 membership shall pay ten dollars.

Constituent Institutional Members shall be entitled to appoint as
 their representatives in the Association any person or persons who are
 eligible to active or associate membership in the Association, and of
 the number so appointed no more than three, including the Superin-
 tendent, shall have all the privileges and authority of active personal
 members and shall be so designated, and others so appointed shall have
 the privileges of associate personal members.

B. Personal

Active personal members shall be those who at the time of their
 election are trustees or superintendents, or assistant superintendents, of
 hospitals, or members of the medical staffs of hospitals, however such
 officials may be designated. Any person once an active personal mem-
 ber may continue such membership so long as the rules of the Associa-
 tion are conformed with.

Associate personal members shall, at the time of their election, be
 heads of any executive, administrative, or educational department of a
 hospital, other than as designated in Section 2, or contributors to, or
 members of, any association or board, the object of which is the founda-
 tion, maintenance or improvement of hospitals or the promotion of
 organized charities for the improvement of health. Associate personal
 members may hold office, but shall not have the right to vote at meet-
 ings of the Association.

Applications for active or associate personal membership shall be in
 writing, addressed to the Executive Secretary, and shall be endorsed
 by one or more members of the Association. They shall be referred to
 the Committee on Membership; and the applicant shall become a mem-
 ber upon receiving the approval of a majority of said Committee, and
 upon payment of an initiation fee of five dollars for active and two
 dollars for associate membership, which shall cover the dues payable
 at the next convention of the Association after election.

Section 2. Upon attaining any of the offices designated in Section 2
 an associate personal member may become an active personal member
 by completing the payment of the dues for active personal members as
 provided in the By-Laws.

Section 3. Honorary personal membership after approval of the
 Membership Committee may be suggested at any session of the Associa-
 tion by any member for any person who by reason of public or
 private service, or for any other reason, should be entitled to such
 recognition; and such person may be elected an honorary personal mem-
 ber by a majority vote of those present at any subsequent session of the
 Association.

Honorary personal members shall have all the privileges of active
 personal members, except voting at meetings of the Association. They
 shall be exempt from the payment of dues.

ARTICLE IV: OFFICERS

Section 1. The officers of the Association shall be a President, three
 Vice-Presidents, an Executive Secretary, a Treasurer, and a Board of
 Trustees as herein provided.

The Executive Secretary shall serve as Secretary of the Board of
 Trustees.

Section 2. The above officers, other than the Board of Trustees, shall
 be elected at each convention, shall assume their duties at the close of
 the convention, and shall serve until the close of the convention next
 succeeding, or until their successors are regularly elected and installed.

ARTICLE V: TRUSTEES

There shall be a Board of five Trustees, which shall have charge of
 the property and financial affairs of the Association, and shall hold
 title thereto under the name of "Trustees of the American Hospital
 Association." The President and Treasurer shall constitute two of
 said Trustees, and one Trustee shall be elected annually, at the conven-
 tion, to serve for three years, excepting that in 1916; one of said
 Trustees shall be elected for one year, one for two years, and one for
 three years. Trustees shall serve until their successors are elected.

The Board of Trustees shall, always subject to the vote of the Associa-
 tion, have general control and management of the business of the
 Association, and may appoint and fix the salaries of such officers and
 agents as it may deem necessary and expedient and establish rules and
 rates for the use of such facilities as it may in its judgment provide.

ARTICLE VI: SECTIONS

In order to facilitate the work of the Association, sections may be
 formed and discontinued from time to time, as the Trustees may by
 vote determine. Such sections may be geographic, in order that recog-
 nized meetings of the Association may be held in various parts in places
 not easily accessible to all members, or may be departmental in their
 nature and devoted to any recognized branch of hospital work. Pro-
 ceedings of any authorized section of the Association approved by the
 Board of Trustees may become a part of the proceedings of the Associa-
 tion, and any resolution adopted by a geographic section shall be
 recognized as a motion duly made and seconded by any general session
 of the Association, and vote of the general Association shall be taken
 thereon.

ARTICLE VII: ANNUAL DUES

In order to provide funds for the maintenance of the Association, both institutional and personal members shall pay annual dues as may be determined by the By-Laws.

ARTICLE VIII: VACANCIES

Any vacancies occurring between the regular annual meetings in the office of the President, the various Vice-Presidents, Treasurer, Executive Secretary or Board of Trustees, shall be filled temporarily by vote of the Board of Trustees; any other vacancies shall be filled temporarily by appointment of the President; and the appointees shall hold office until their successors are elected by the Association.

ARTICLE IX: AMENDMENTS

The Constitution and By-Laws may be amended by vote of not less than two-thirds of the members present and voting at a recognized general session of the Association; provided, however, that proposed amendments shall be submitted in writing at a recognized general session, and shall not be acted upon at a session at which they are proposed, but may be at any subsequent session.

BY-LAWS

ARTICLE I

Section 1. There shall be an annual meeting or convention of the Association held at a time and place fixed by vote of the Association, or, if not so determined, by the Board of Trustees. The President and the Executive Secretary shall arrange programs for the convention.

Section 2. Special meetings may be called by the President, or in his absence, by a Vice-President, upon the written petition of not fewer than ten (10) members. This petition shall recite the object of the meeting. The President, through the Secretary, shall give notice of not less than sixty (60) days before the proposed time of such special meeting to each member of the Association, which notice shall also recite the object of the meeting.

Section 3. A quorum of the Association shall consist of not fewer than thirty (30) voting delegates or active members.

Section 4. Meetings of sections shall be held in accordance with the rules established by the enrolled members of the section hereinafter provided; provided, however, that such meetings shall not interfere with any general session of the Association.

ARTICLE II: ELECTIONS

Section 1. All officers shall be elected by ballot, excepting where it is otherwise ordered.

Section 2. A majority of the votes cast shall constitute an election.

Section 3. Only the delegates of the constituent institutional members so authorized by Article III, Section 1, and active personal members shall be entitled to vote.

ARTICLE III: DUTIES OF OFFICERS

Section 1. The President shall preside at all meetings of the Association, and of the Board of Trustees, of which he shall be the Chairman. He shall appoint all committees, unless, by vote of the Association, other provisions shall be made. He shall be, ex officio, a member of all standing and special committees.

Section 2. The Vice-Presidents shall, in the order of their rank, in the absence of the President, perform his duties.

Section 3. Subject to instructions from the Association or from the Board of Trustees, the Executive Secretary shall be the general executive officer of the Association with duties, responsibilities, and privileges such as generally accompany such executive positions. He shall keep the minutes of the meetings and the records of the Association in books provided for these purposes. Subject to the order of the Trustees, he may serve as secretary of standing committees, except the Committee on the Nomination of Officers, and perform such other duties as the Association and the Board of Trustees shall direct. Under the direction of the Trustees, the Executive Secretary shall report to the Association the proceedings of the Trustees and also make such report of his own services as may be advisable.

Section 4. The Treasurer shall receive all dues and other moneys of the Association and shall deposit and account for same, under the direction and control of the Board of Trustees. He shall give to said Board such bond as it shall determine for the faithful performance of his trust. Such bond shall be in the custody of the President. All disbursements and expenditures shall be made under the direction of the Board of Trustees and subject to its rules and requirements. The Treasurer shall keep proper books of account, and shall present a report of the finances of the Association at the annual meeting.

ARTICLE IV

Section 1. The President shall, immediately after his election, appoint a Committee on Local Arrangement to consist of the President and Executive Secretary ex officio and such additional persons as he may deem advisable and also the following standing committees of three members each: namely, A Committee on Constitution and Rules, a Committee on Nomination of Officers, a Legislative Committee, a Membership Committee, and a Committee on Time and Place of Next Meeting, composed of a trustee, the Executive Secretary and a member at

large, and the President shall also appoint a standing committee on Out-Patient Work to consist of three members appointed by the President. The terms of office at the first appointment shall be so adjusted that one member shall go out of office annually. This Committee shall undertake such study or activity as may advance progress of out-patient service and shall report to the Association.

Section 2. The Committee on Nomination shall nominate to the convention the names of the candidates for President, three Vice-Presidents, Executive Secretary, Treasurer, and one or more Trustees as vacancies exist. The action of this Committee is at all times subject to the approval of the convention.

Section 3. The members of the Membership Committee shall consider all applications for membership, determine the eligibility of the applicant and express their approval or disapproval thereof to the Executive Secretary.

Section 4. The Committee on Constitution and Rules shall consider and report on all proposed amendments in the Constitution and By-Laws and all Rules of Order.

Section 5. The President shall have the power to appoint such special Committees as may be deemed desirable.

Section 6. The Legislative Committee shall so far as possible inform itself concerning all legislative procedure affecting the Association or the interests which it represents. Subject to the approval of the Association or Board of Trustees, it shall actively support all desirable legislation and actively oppose all unwise legislation.

ARTICLE V: DUES

Section 1. Constituent institutional members shall pay annual dues as follows: Hospitals of less than 100 beds shall pay annually \$10, hospitals of 100-250 beds shall pay annually \$25, hospitals of more than 250 beds shall pay annually \$50. All other institutional members shall pay annually the sum of \$10. States, counties, and municipalities shall pay in accordance with the above schedule for each institution accepted to membership. The maximum amount in such case shall, however, not exceed \$100.

Section 2. Dues of active personal members shall be \$5 and of associate personal members \$2 for each calendar year. Life personal members are exempt from the payment of annual dues. Dues shall be payable on or before the first day of March of each year at the office of the Executive Secretary, provided, however, that the dues of members acting as the delegates of institutional members shall, upon request of such personal members to the Treasurer, be remitted for the period of delegation.

Section 3. If said dues are not paid on or before the closing of the annual convention for the current year, the Executive Secretary shall notify the members in arrears, enclosing a copy of this section; and if said dues are not paid on or before the succeeding first day of January, the delinquent member shall be suspended and thereafter shall not be entitled to receive notices, or copies of transactions, or to participate in the meetings until all arrears are paid in full.

Section 4. At any time within three years after the date when dues are first required to be paid, a member who has been suspended shall be reinstated upon the payment of the amount of dues at the time of suspension. Otherwise membership in the Association shall be terminated.

ARTICLE VI: PUBLICATION OF PROCEEDINGS

Section 1. The Executive Secretary shall furnish the minutes and proceedings of the regular meetings for publication as soon thereafter as practicable.

Section 2. The Executive Secretary shall furnish to each member, except as provided in Article V, Section 2, a copy of this publication.

Section 3. The Treasurer shall upon the certification of the Executive Secretary pay all bills for printing and publication of the proceedings of the regular conventions.

Section 4. No paper shall be published in the minutes or in any magazine or paper as a part of the transactions of this Association except with the approval of the Trustees. All papers read at any session of the Association or its section shall become the property of the Association, and when so requested the Board of Trustees may cause the same to be copyrighted in the name of the Trustees; but unless prohibited by the Trustees the authors of all papers read at sessions of the Association or its sections may cause the same to be published, and, if approved by the Trustees they may be published as a part of the transactions of the Association. No paper or magazine shall be entitled to the exclusive publication of any paper read before the Association or its sections except by vote of the Trustees.

ARTICLE VII: SECTIONS

Whenever a section is established by the Association or Trustees as provided in the Constitution, the President shall appoint a chairman and secretary thereof; and thereupon any delegate or member of the Association may become a member of such section by enrollment therein. When ten (10) or more delegates or members have so enrolled, the chairman shall call a meeting of such delegates or members, and they may thereupon make proper rules and by-laws for the guidance of such section, subject to the approval of the Trustees; and such rules may provide for the method of holding meetings, election of officers, and

other matters necessary or important for the proper conduct of the section. The chairman and secretary appointed by the President shall act until their successors are chosen by the members of the section in accordance with the by-laws established by such section.

ARTICLE VIII: GUESTS

Delegates and members of the Association may have the privilege of inviting guests to the meetings, under such rules and regulations as the Trustees may from time to time provide. Guests thus introduced shall be permitted to participate in discussions.

ARTICLE IX: DISCIPLINE

Section 1. All charges of violation and infraction of rules or unbecoming conduct shall be referred to a special investigating committee of five appointed by the President.

Section 2. Due notice of the charges shall be given to the alleged offender, in writing, by the Executive Secretary of the Association.

Section 3. The Association shall have the right and authority to reprimand, suspend and expel any delegate or member guilty of violation of any of the provisions of the constitution or by-laws of the Association, after a full and fair investigation shall have been made.

Section 4. A four-fifths vote shall be necessary to sustain the action of such committee.

ARTICLE X: AMENDMENTS

These by-laws may be amended as provided by Article IX of the constitution.

Adopted Sept. 26th, 1918, at the Annual Convention American Hospital Association, Atlantic City, N. J.

Sickness and Health Insurance

The following resolutions were adopted at the last session of the convention at Atlantic City but have not heretofore been published:

WHEREAS, the subject of social health insurance has assumed a position of first importance in public discussion and is now recognized as an inevitable social policy in this country, and

WHEREAS, the proper solution of the problem, including the formation of legislative bills and the administrative organization of the plan are of prime importance to the hospitals and dispensaries, for the reason that the fundamental basis of such insurance should be the medical treatment and rehabilitation of disabled wage earners; therefore be it

Resolved, by the American Hospital Association that the importance of health insurance investigation be recognized by this body and the board of trustees be directed to make a study of the subject in its relation to the hospitals and dispensaries; that the board of trustees give such assistance as may be requested in the formulation of plans and of legislative bills; that the members of this association and the state hospital associations be urged to give the subject careful study and to cooperate wherever possible in effective solution of the problems unsolved.

This resolution, together with the report of the legislative committee, published on page 331 of the October number of THE MODERN HOSPITAL, are again called to the attention of the hospitals. A paper on this subject, read by Mr. John A. Lapp at the convention, published in the November number of THE MODERN HOSPITAL, should also be read, as well as the paper by Dr. Thomas Howell, published in this number of the journal. As pointed out in the legislative committee report, health insurance will revolutionize hospital responsibilities. Hospital representatives should, therefore, take part in the framing of all such legislative proposals.

In accordance with instructions, copies of the above resolution, as well as of the part of the report of the legislative committee dealing with this subject, have been sent to the secretaries of the health insurance commissions in the following states: California, Connecticut, Illinois, New Jersey, Ohio, Pennsylvania, Wisconsin.

Also, a letter offering the cooperation of this association. The Connecticut and Illinois commissions have already set dates for hearings. Hospital officials in both of these states have been urged by this association to attend these hearings and to give the commissions information.

Twenty-first Annual Convention

Plans for the 1919 convention of the association are already under way. The secretary has been to Cincinnati to confer with local hospital people relative to the ap-

pointment of a local committee and the selection of headquarters.

September 29 and 30, October 1, 2, and 3 have been tentatively set as the days for the meeting.

The names of the local committee and the hotel headquarters will be announced in the January number of THE MODERN HOSPITAL.

Official Minutes of the American Hospital Association*

TWENTIETH ANNUAL CONVENTION, ATLANTIC CITY, SEPTEMBER 24 TO 27, 1918, INCLUSIVE

TUESDAY MORNING, SEPT. 24, 1918.

The convention was called to order by the president, Dr. Arthur B. Ancker, St. Paul, Minn.

The report of the committee on institutional membership was read by Dr. A. R. Warner, chairman, who presided during the discussion of the same at the request of the president. After discussion and upon motion duly seconded, the report with its proposed amendments to the constitution was made a special order of business for Thursday morning, Sept. 26, at 9 o'clock.

The report of the secretary, including the membership and publicity committee reports, was read.

Resolutions of loyalty to the President of the United States were adopted by a rising vote.

The president appointed members of the time and place committee and additional members of the auditing committee.

The meeting adjourned until Wednesday, Sept. 25, at 9 a.m.

WEDNESDAY MORNING, SEPT. 25, 1918.

The meeting was called to order by the president.

Upon motion duly seconded, the president was authorized to appoint a special committee on resolutions of nine members, and the names of the members were announced.

A communication from the Assistant Secretary of War to the convention was then read and referred to the special committee on resolutions.

The report of the war service committee was then read by the secretary, Mr. Richard P. Borden.

Resolutions expressing appreciation to the War Department for its cooperation with the association and its committees were adopted.

A telegram from Samuel McCune Lindsey relative to the Federal Inheritance Tax Exemption before Congress was read and referred to the committee on resolutions.

The meeting adjourned until 2 p.m.

2 p.m.

The meeting called to order by the president.

By unanimous vote, resolutions of good will to the Catholic Hospital Association were adopted.

The meeting adjourned until 8 p.m.

8 p.m.

The meeting called to order by the President.

Miss Georgia M. Nevins, chairman of the section on nursing, presided at the request of the president.

Resolutions endorsing the Lewis-Raker bill providing for nurses' rank were unanimously adopted.

The meeting adjourned until Thursday, Sept. 26, at 9 a.m.

THURSDAY MORNING, SEPT. 26, 1918.

Dr. A. R. Warner, vice-president, presiding.

As a special order of the day, the report of the committee on institutional membership, with its various amendments to the constitution, was called up. Several minor amendments were adopted and, upon motion duly seconded, the report of the committee was unanimously adopted. (The new constitution is printed in this issue of THE MODERN HOSPITAL.)

The report of the treasurer was then read and approved.

The meeting adjourned until Friday, Sept. 27, at 9 a.m.

FRIDAY MORNING, SEPT. 27, 1918.

The meeting called to order by the president.

The report of the legislative committee was then read and referred to the board of trustees.

The report of the accounting committee was then read by Mr. Cornelius S. Loder and referred to the board of trustees.

Resolutions pertaining to the following matters were then adopted: Hospital social service work, control of venereal disease, hospital as-

*Practically the entire proceedings of the Twentieth Annual Convention, including a story of each day's meetings, as well as the official papers, reports, addresses, and resolutions adopted, with discussions of the same, have already been published or will appear in the next two numbers of THE MODERN HOSPITAL. Copies of reports made, resolutions adopted, and names of committees appointed are filed with the official minutes. The following is a record of the official business transacted at the meeting. It does not include routine business proceedings of the various sections of the Association.

assistants, graduate medical students, hospital employees, organization of civilian physicians for military service, Red Cross survey, affiliation with army training school for nurses, use of existing hospital facilities, nurses in captivity, Federal Inheritance Tax Bill.

The nominating committee then reported, and the following were elected: president, Dr. A. R. Warner; first vice-president, Dr. Joseph B. Howland; second vice-president, Mr. A. B. Tipping; third vice-president, Sister Irmena, R.N.; treasurer, Mr. Asa Bacon; executive secretary, Mr. Howell Wright; trustee for five years, Dr. Robert J. Wilson.

The meeting adjourned until 8 p.m.

8 p.m.

Dr. A. R. Warner, newly elected president, presiding.

The report of the auditing committee was then read by Mr. Cornelius S. Loder and adopted.

The report of the time and place committee was then read and adopted.

Resolutions pertaining to health insurance were unanimously adopted. (These resolutions are published in this number of THE MODERN HOSPITAL as a part of the Bulletin of the association.)

The convention then adjourned *sine die*.

HOWELL WRIGHT, Executive Secretary.

The Institute of Reeducation for Crippled Soldiers in Bologna

Among the Italian reeducational establishments, the institute for crippled soldiers at Bologna takes a prominent place. The building, formerly a convent, is a substantial and modern structure, but considerable changes were made to adapt it to its new destination. A new, large pavilion was added, so that the institution now has room for 165 crippled men. The well-lighted basement of the main building contains the kitchen, a dining room for the nurses, the laundry, and a large basin for bathing. The central portion of the first and second floors is taken up by the chapel, which was not changed. The first floor contains, in addition to the rooms for the nurses, a large recreation hall for the soldiers and a large covered gallery in the rear of the building. On this floor is also the school of telegraphy and typewriting. The third floor contains a large number of small rooms for the soldiers. Several large dormitories in neighboring buildings have also been procured to house a portion of the soldiers. In the annex are located the various workshops, the carpentershop, the shoeshop, the shops for wickerwork, wood-turning, book-binding, etc.

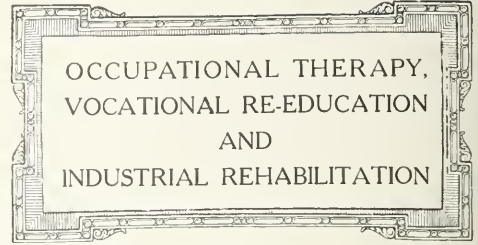
A pupil newly entered is left to himself for a few days. He attends the lectures, visits the various shops, and thus has time to consider the selection of a trade.

The institute is described in a recent number of the *Rivista di ingegneria Sanitaria* of Turin.

The Treatment of External Tuberculosis by Heliotherapy

In a recent article Dr. Cazin defends heliotherapy against the attacks of writers who have not used this method in a rational and approved manner and therefore were bound to fail. Untoward accidents, such as congestions, fever, erythema, etc., result only if the well-established rules based on experience are disregarded. If a healthy man, by a sudden and long-continued exposure to the sun, may suffer serious injuries, the same is even more true in the case of a sick person. The beneficent and efficacious effects of the sunrays are undeniable, for they not only influence the local lesions, but have a general tonic effect on the whole system. In Pott's disease, the combined method of heliotherapy, immobilization, and compression has cured thousands of cases. But heliotherapy is not a panacea, as its opponents wish to represent it in their attacks.

Dr. Cazin's article appears in the *Paris Gazette des eaux*.



Conducted by DOUGLAS C. McMURTRIE, Director Red Cross Institute for Crippled and Disabled Men, and ELIZABETH G. UPHAM, Advisor in Occupational Therapy, Milwaukee-Downer College.

HUMAN FACTORS IN THE RECONSTRUCTION OF DISABLED SOLDIERS AND SAILORS*

**Influence of Community and Reaction of Man Himself
Two Most Important Factors in Rehabilitation Process—Education of Family and Public
Necessary—What Cripples Can Do**

By DOUGLAS C. McMURTRIE, Director, Red Cross Institute for Crippled and Disabled Men, New York City, President, Federation of Associations for Cripples, New York City.

The subject of reconstructing the crippled soldier and the cripple in general has become so well known and has been so widely represented in literature that I am going to assume you are fairly familiar with the theory and practice of the work. What I want here to speak about is your relation to it and, more broadly, the relation of the public to it. We may have the best reeducational system in the world, the best schools, the best classes, and the best courses, and yet the whole program of rehabilitation may break down and be a failure unless the human factors involved are taken into consideration and dealt with in the wisest manner. The two human factors to which I refer are, first, the influence of the community—at large and individually—on the disabled soldier or sailor, and, second, the reaction of the man to the program and the spirit with which he enters into it.

The first community influence which is brought to bear upon the disabled man is that of his family. I can best illustrate the importance of this and the way in which it operates by telling you an incident from the French experience. As you know, in France the mother of the family occupies a rather unusual position. She is the "boss," and, although her boy may grow up to be twenty or thirty or forty-five, mother still holds a position of rather unusual authority. In some of the French centers of physiotherapy, as they call them, it was discovered that about the time a man was completing his hospital care and was ready to enter upon reeducation, his mother would come in from the provinces or suburbs, very much upset. She would claim they had kept her boy too long and she had come to take him away because she wanted him where she could lavish her love on him and take care of him for the rest of his life. Although they would try to explain that they wished to train her son so as to put him back on his feet when he went home, it was too late to make the explanation. Mother made a scene, beat her umbrella on the table, and usually carried the boy away with her. She was running exactly counter to his best

* Read before the Twentieth Annual Convention of the American Hospital Association, Atlantic City, N. J., Sept. 24-28, 1918.

interests, yet did not know it, and they could not make her understand.

Finally, a new system was tried. When the hospital care had proceeded to a certain stage, the authorities sent for mother and said, "Your son's medical treatment is almost completed, and we thought you would like to know, in case you planned to take him away. Of course, you intend to take good care of him, but you know you will not live forever. The small pension the government gives will not meet all his necessities. You remember the disabled men from the War of 1870, and you know what they were doing ten years ago—begging on the street corners. You would not want your son to come to that. Across the street is a school of reeducation, where we can give your son a training course in telegraphy, and he will go back to his home village and be able to get a job with the government telegraphs. Instead of being an idle, useless person, he will be a skilled artisan again, worthy of the respect of the community, and you will be very, very proud of him." The whole situation has changed. Mother goes into the hospital ward and says, "Son, have you heard what they are going to do for you?"

That is the difference between having the family behind the program of the government and having them opposed to it. Unless we can put the families of American soldiers behind the program of reeducation and rehabilitation, that program will fail.

One of the first things we can do for families—and I think it behooves us to do it—is to take a good deal of the terror out of going to war. For the men who are going away the chief concern is not getting killed; it is coming back disabled. They all say that they would much rather be killed, and their families have the same point of view. I was coming down the elevator in a big department store in New York a while ago, the day after a leading newspaper had printed in its pictorial section a photograph of the first amputation cases in the American Expeditionary Force. None of them were more serious than just above the ankle, and those of us who know what can be accomplished with the modern artificial limbs do not regard such amputations as real handicaps. One lady said to the other, "Did you see those horrible pictures in the paper yesterday?" And the answer was, "Yes, I did. I hope Jack won't come back that way; I would rather he were killed." If people knew how much, or rather how little, that kind of disability really means when a man comes home ready to do his best and when the government makes the provision it has, how much worry would be eliminated!

Then let us suppose that the disability has occurred—and it may never happen. In a little town outside of Philadelphia a short time ago they found a woman in a dead faint on the steps of the post office. When they finally revived her, it was found that she had opened a letter from her son abroad which told of an amputation of his arm in the hospital. She was absolutely inconsolable, and said she knew that it was worse than death and that there would never be anything worth while for her son. If in that state of mind she writes to her son, it is in this spirit: "My son, I am terribly, terribly sorry that you are going to be laid aside and that you are going to be forever incapable of doing useful work." Such a reaction is not going to help the fellow at all.

We must see that members of the family know the game, know what we want from the man, and what will be done for him, so that their influence on him will help rather than hinder. Training must always be voluntary. You cannot force a man to take training, because, although you may, while he is under military discipline, be able to

compel his attendance in a classroom, you cannot compel his attention and cannot conscript his enthusiasm. Unless you have these, there is no education of an adult. So it must be voluntary. You must bring a man to the decision to undergo training, and, to secure the best results, you must also have his family's consent. You must further have his family's continued backing while he is under training, and you must have the same kind of morale as is maintained for the man's benefit when he is away at the front. Every letter from the family must not say in effect: "William, I think you have done this long enough; you had better come home. It is time you got back to work and did something worth while, instead of fussing around this training school business that I haven't much confidence in." They must say: "We are with you, old fellow; stick right to it and finish it; if you do it well now, you will have it settled forever."

Of course, in this work, the social service worker is the one who can accomplish the most. The home service workers of the Red Cross are in touch with the families of a large proportion of the men. Of course, there are other families with whom this service is not in touch, and we must try to reach them in every possible way.

After the man comes home, there are a few obstacles for the family to overcome. The period of adjustment will be a rather difficult one. The man, taken away from family responsibilities and home ties, is sent to France for one, two, or three years, and comes home after having lived a life of continuous excitement, always out in the open, always under pressure. He is going to find it a little hard to come back to five youngsters and food perhaps not of the best, as well as to some of the other difficulties that ensue in the domestic routine. The situation with the disabled soldier is going to be doubly difficult, and it will require all possible tact on the part of a family and the family's advisers to get through the period.

Again, the family's reaction too often will be: "Well, you have done your bit; you have been injured. Now it is up to the government to take care of you. Settle back and take it easy; believe me, you have earned it." What they are advising is the most desperate thing for the man that can be imagined. They are also liable unduly to coddle a man who is disabled. A man who is disabled physically, in the eyes of the ordinary citizen, is a helpless creature; in the eyes of those who have been used to working with cripples, he is not at all helpless, but entirely able to do everything for himself. We want the family to understand this; we do not want to have him waited on hand and foot, encouraged to do nothing for himself, and become practically an imbecile.

One of the most interesting features in the rehabilitation of American blinded soldiers is that in connection with the training school in Baltimore, where a house has been established to which the families of the blind men are invited. The object is to train the families reeducationally and to show them what the blind can do, so that, when they come home, instead of saying, "Don't go upstairs, you might fall," they will expect the man to go about the house and garden and do everything for himself. They will continue the same quiet encouragement that he has had during his training; in other words, they will carry forward his reeducation in his home. That is the ideal; we want to approximate it as closely as we can.

Another necessity is to impart the right spirit and a sound social philosophy to the people who are dealing at first hand with the disabled soldier, to the nurses, to the doctors, to the aides, etc., who come in contact with him both on the other side and after his return. This is quite a mechanical problem, because the medical forces that

went abroad in the early months of the war are not familiar with what is being done on this side and are not acquainted with the new method of dealing with the disabled. They must be informed, so that their treatment is sound socially as well as medically.

The employer exerts a community influence on the disabled man. If left to himself, the average employer will get together with a committee of his fellows and deliberate about as follows: "Well, we have twelve disabled men who have come back from abroad—heroes; we must certainly look out for them. Now, Jones, you ought to be able to take care of six of these men in your factory, and, Smith, you could certainly put four in your warehouse, and, Johnson, you can place two in your store;" and, conceiving their patriotic duty in that way, they accept the assignments. Jones goes to his superintendent and says, "I have just agreed to employ six disabled soldiers, so plan to make places for them." The superintendent looks at him aghast and says, "Where?" "Oh, I don't know, you fix them up some way." So the superintendent adds six messengers or six doorkeepers to the plant. The disabled soldier is paid \$20 a week, let us say, for being a doorkeeper, because it is considered patriotic and because the community wants to take care of the boys that come home. What happens? The disabled soldier goes into the job and takes his \$20. He knows he is not earning that money and soon realizes he is an object of charity. Every day that man's character is being broken down, and he is being made a less useful citizen.

Furthermore, jobs of the character described have no future; the ex-soldier will keep on being a doorkeeper as long as he lives. Then, patriotism on the part of the employer does not last. It may last for six months after the war is over, perhaps for nine months, peradventure for eighteen, but, at the end of that time, when the next commercial depression ensues, the plant is forced to sift down its pay-roll. These disabled men will be the first to go. They will go in the most desperate economic condition a man can imagine, with no confidence and no nerve, no experience, and no training. They will be turned out with their physical disabilities, and will be in a bad way indeed. That is taking care of the soldier from the patriotic point of view alone.

We need more than patriotic willingness; we need intelligence as an added ingredient. We must protect disabled men from employment in jobs of that kind.

When we speak of reconstructing a disabled man and putting him back on his feet again in a position to earn as much money or more than he ever earned before, the first reaction is that of incredulity: "It cannot be done." Let me give several instances that convey some conception of the way in which it can be done. If you were given a case of a man with both legs off above the knees, you would consider him seriously handicapped. Any pension board in the world would classify him as totally disabled; any workmen's compensation commission would classify him as totally disabled, and that man would be theoretically set aside to do nothing for the rest of his life. He is seriously disabled, but not to such an extent that he cannot earn \$30 a week with ease. Let us take nine months to train that man as a linotype operator. He can use his hands and head in full measure and can do as well at a linotype job as any man with all his faculties intact—if he has the training. That man, therefore, with two legs gone, is no longer handicapped economically. In a big automobile works of which you all know, disabled men have assembled engines passing along on an endless belt. The cylinder heads have to be sealed with a certain kind

of compound, and as they pass, a man takes a brush and runs it around the top of the cylinder. If that man had two hands, he would have one in his pocket and be working with the other. He has only one, and does the work with that.

In a report on work for the blind abroad, I read lately that a great many blind men were employed in a clock factory. The modern clock has for a gong a spiral tempered wire which must be tested to determine its tone and adjusted by a screw on the end to make the tone come right. They use blind men exclusively for that job, which is a highly skilled one. Could a sighted man do any better than a blind man in that position? Certainly a blind man is under no handicap whatever. In a large factory making magnetos for high-class automobiles, go to the assembly bench and you will find a blind man working deftly. Is a blind man a poorer or a better employee in that job than a man with sight? The employer considers him a better one, because he does not look out of the window to watch a girl walking down the street; he goes at his job and keeps at it until he finishes, and he never makes a mistake.

The sense of touch is more delicate, it seems, than the sense of sight. In one electrical works where porcelain insulators are put on a certain product, a member of the firm said they had put on about 1 percent of defective porcelain pieces, which later had to be thrown out by inspectors. Since they have employed blind men on that work, they have never had one piece of defective porcelain and have dismissed their force of inspectors.

I do not mean that rehabilitation of the disabled is easy, but I do mean that it is possible, and in the multiplicity of industrial processes today, you can, by looking far enough, find jobs for a man with any kind of disability, which he can fill as well as his able-bodied fellow.

Let us now consider the influence of the public at large. We pity the disabled man and pity him so obviously that he comes very soon to pity himself—and a very natural thing it is. In practically all the French schools for the blind you can see on the wall—the blind men, of course, cannot see it themselves—"Don't Pity the Blind;" and by that they mean, don't pity them in their hearing. This has become necessary because the first reaction of every visitor was, "Oh, the poor things!" This was desperately wrong, because the very thing they were trying to do was to encourage the blind man and tell him he had everything before him. The universal reaction: "That is a shame—oh, what a pity!" is anything but helpful.

We must inculcate in the public a belief in the capability of the cripple and of the man with other types of disability. We must put across publicly the conception that the cripple can do things if we will only regard him in the light of his ability rather than in the light of his disability—if we will forget the disability he has and seek for him some jobs in which his ability will become effective.

From one of the New England towns to which have returned quite a few disabled soldiers it is reported that no one could tell whether they were suffering from shell-shock or intoxication. The average man on the street thinks the best way he can show his regard for the soldier who comes back from the front is to buy him as many drinks as he can at the corner saloon. Luckily, that opportunity will not exist for long. But it exists now, and it is indicative of a very pernicious attitude toward the disabled man.

From Montreal, several years ago, came the report of difficulty caused by the fact that the men who came back disabled were being spoiled by the community. One man in particular, whose family had been under the care of the

Canadian Patriotic Fund, returned from the front. His wife and children had been looking forward anxiously to his homecoming. But they did not see much of him. A holiday, however, was coming, and they finally elicited the promise from father that he would take mother and the children out to the park that day. The morning came and mother began to get the youngsters ready, but father showed no signs of starting. Finally she asked him, "Aren't you going to take us out to the park to-day?" He replied, "Oh, no, I have got to go to a sing-song at the Ritz this morning and for a motor ride this afternoon." The society ladies were helping the returned hero to build up his character! You will find this attitude so universal that, in many ways, it is the most dangerous influence with which we have to deal.

In dealing with the public as a whole, we must urge that every influence on the disabled man be measured as to whether it is constructive and helps to build up his character or whether it is destructive and tends to break it down. Luckily, we have at our disposal an agency to deal with the influence on the disabled soldier, in the form of public education. Public education I consider one of the most necessary elements in any national program—though it has been neglected, to their great sorrow, by some of the foreign governments. They have built up systems of rehabilitation, but the public has not understood them; and the public has spoiled them or is spoiling them very fast.

We can reach the man in several ways—in the first place, by direct statements, cards, booklets, and the like, which can be distributed in the hospitals, which will tell him what the program of reeducation is and what the nation seeks to do for him when he gets better. You can picture the ordinary reaction of the man who is disabled. He is not only a well man, but he has been selected from the physical pick of the country. When he is struck from that condition into a condition of what he conceives to be total disability, he is pretty much discouraged, because he knows that the man who worked next to him in the machine shop or factory, who was earning \$35 a week, is now selling shoestrings on the main street, and he could go on and repeat in his mind thirty or forty instances of that character. He knows that physical disability has meant dependence, and you have to start at the earliest possible moment to admit past faults and tell him that we are learning and have something better in store for him.

One of the interesting things that has been done is the preparation by the office of the Surgeon-General of the Army of a series of educational films entitled "The Way Out," which gives the history of successful American cripples and demonstrates that losing an arm or a leg does not necessarily mean helplessness. They are being shown or will be shown at all the military hospitals abroad and in this country. I remember the story of a man in Kansas City who, the moment he heard of a man run over in the street, made it a regular practice to go to him at the hospital and say, "Don't worry, you have only a leg gone, and I have a leg and an arm gone and it doesn't worry me a bit."

That is the policy of encouragement of cripples by cripples. The Germans have issued a book entitled "The Will Prevails," which gives the autobiography of a thousand successful cripples from the middle ages down, and it teaches that, if a man makes up his mind to make good, he is not crippled at all. We have at Baltimore the Red Cross Institute for the Blind, and the first American soldier who returned blind got along finely, caught the spirit of the thing easily, and became encouraged and was making good progress. The first American sailor who came

there wanted to commit suicide. Nobody could do a thing with him; he wanted to die and die quickly. They could not make any progress with him until finally they decided to let the blind soldier take him in hand. They left the two together, and in three days they were going about laughing and the sailor was on his way to success.

Another influence is organizations of cripples themselves. In one of the leading French schools of reeducation there is an alumni association which is called upon to settle all difficulties that arise. The alumni can give the trainees the practical benefits of their experiences, and their arguments are more persuasive than good theory.

Now, there remains the part the family can play in the program of reeducation. We can reach the family through general publicity, because most of the people we reach now are families of soldiers, and we can also reach them through the home service of the Red Cross or similar organizations, for one of the responsibilities the Red Cross Home Service has undertaken is the education of the people under its care.

The employer can be educated in several ways. The Red Cross Institute for Crippled and Disabled Men in New York City has been trying to reach him through the chamber of commerce. Practically every chamber of commerce has transmitted a message to its members with its endorsements, telling them the wrong and the right way of intelligently helping. The public at large can be reached through every possible form of communication, and can be reached directly. The American Telephone & Telegraph Company recently distributed in the United States for the Red Cross five and a half million folders which pointed out the duty of the public toward the disabled man.

The newspaper, by stories of what is being done in the field, makes reeducation appear a logical and practical thing. The magazines also assist in this, and one of the essential things being done is to educate the writers of the country to present to their readers the cripple in his proper light. In the past, when a cripple was mentioned in a book or in an article, it was with a sob—and a very hopeless sob, at that. We want to change all that, because that sort of thing is not constructive.

Public speaking, of course, is another valuable medium of publicity. We assume there will be built up a service of public speaking through the country which will carry to everybody the general gospel of reeducation. The theory is not obvious; what we tell the employer is not obvious, but it is logical and he understands it. Once he has heard it, he will never slip back to his old conception of disability.

Now, the other human factor is the spirit of the man himself. In the past, we have been accustomed to speak of cripples as beggars, and as "down-and-outers," and I think for that we have only ourselves to blame. The cripple usually starts right; he does not want to be dependent. The average man comes from some useful activity; he is injured and does not want to be an object of charity. He does not want to beg, but, by his relationship to the public, he is driven into the status and attitude of a pauper. A railway surgeon from the West told me quite a few years ago that in his experience—and we did not talk then of scientific care for cripples—"whenever a man is run over on a railroad, I know if I can get hold of him the day he comes out of the hospital, I can make a success of him, but if I let him go three weeks, he is gone." This statement all of you can probably verify from your own experience. If you start the man right and arrange so that he will not be subjected to too much discouragement and adverse influence, he will succeed.

I wonder if you realize just what cripples can do—what

American cripples can do when they summon their nerve to it. We have in New York at the Red Cross Institute a good many civilian cripples whom we are trying to put on their feet. We find that one of the most helpful things we can do is to arrange cripple parties or meetings in which they are brought in contact with other cripples who are not "down-and-out," but who are making good. One of these meetings made a deep impression on me. There were four or five speakers, all of about equal caliber and success, but I have time to tell you only of two. One was a man from the Southwest who was run over in a railroad accident and both his arms were taken off. One arm was taken off—in fact, it was not an arm amputation, because part of his collar bone was gone as well—and the other arm was amputated just below the elbow. That is a tremendously serious handicap, infinitely more serious than a double leg amputation, because, with both arms gone, a cripple is subject to the ignominy of having people dress him and look out for him generally. This man did not want to be a beggar and tried to make his own way, but the road was hard, and discouragement met him at every turn. He said that in a short length of time he called on two thousand employers asking them for a job, but they all looked a little embarrassed, smiled sympathetically, handed him half a dollar, and said that they did not have any jobs at the moment. It was always the half dollar and never the job. Almost reduced to begging food from door to door to keep life in his body, he still retained his ambition. He knew one man, a friend of his father's, and to him he said: "I am not going to ask you for a job, because I know you would laugh at me, but you have a lot of jobs and I am going to ask you to let me take a chance at some of them and see if I can do the work. Just let me try; don't put me on the pay roll."

The man let him try. He was in the contracting business, and among the things he did was laying street paving. One of the jobs was to check the number of paving blocks issued to the workmen. The cripple said, "I can do that as well as a fellow with two arms." He did—with the result that he was put on the pay roll and started to advance. He began studying law in the evening and was admitted to the bar. Meanwhile he had been working on his own artificial apparatus, and, in comparison with all the scientific devices developed abroad, we consider that his apparatus, devised and manufactured by himself, with both arms off, is as ingenious as any we know. He studied law, manufactured his apparatus, and did all he could to help other men with two arms off. He is interested, not in one arm cases, but in double amputations. He ran for justice of the peace, was elected, and then ran for county judge. Quentin D. Corley has now for three times been elected to that latter office. He prunes his own peach trees, runs his own automobile, and does everything for himself, even to taking off his collar and tie. You can insult him in only one way, and that is by offering to do something for him.

The other speaker was a man who was out in a blizzard and, as the result of exposure, had his four extremities frozen. When he recovered, he had to have amputated both legs, one arm, and four fingers off the other hand. He had no resources whatever. The county supervisors of the poor took him under their custody and agreed to support him. Soon he got tired of being kept by the county and said, "I have to make good; I haven't any limbs; the only thing about me that is not cut up in some way is my head; I guess I had better start to polish up the machinery above my neck." He went to the three supervisors and said, "I want to make you a sporting proposition; I

am healthy, I will live on you until I am ninety if you leave me here, but if you will give me one year in college, I will never cost the county another cent." They deliberated until the early hours of the morning before reaching a decision, and, in the words of the disabled man, "Thank God, there were two sports on the board." He made good; he carried out his end of the bargain, and Michael Dowling has since been speaker of the House of Representatives in the state of Minnesota and is now president of one of the most prosperous banks in that state. He married since his accident and has three daughters, one of them now going through one of our leading girls' colleges and her sisters prepared to follow her. He drives his own automobile, and he says that physical handicaps disappear the moment you make up your mind to conquer them.

These are the human possibilities. A European writer says in what is, to me, a very inspiring way, "There are no more cripples," and the work that is being done in rehabilitation is certainly demonstrating the truth of that statement today. Physical handicaps, yes—but social and economic handicaps, no. Some of the men who are abroad today are coming home disabled; they are coming home to a task greater in some ways than the one which they are doing so well now. I am confident that they will discharge that task and win their second victory so that we will be as proud of them then as we are now proud of them in winning their first. And I am confident further that you—and the American public—will not put one straw in the way of their success.

Emergency Course of Training for Reconstruction Aides

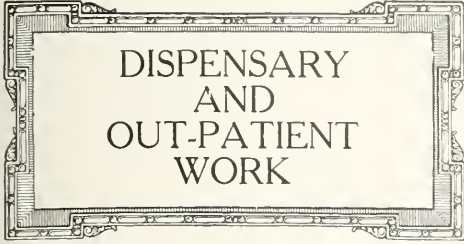
In accordance with the call issued by the Surgeon-General for a thousand women to serve in military hospitals at home and overseas in the teaching of hand crafts and other subjects to disabled soldiers, the committee of the National Society for the Promotion of Occupational Therapy has set up an emergency course to be used in the training of reconstruction aides. The proposed qualifications and requisites for entrance to this course are three: age, educational, and special. Applicants should be between twenty-three and forty-five years of age, although exceptions may be made for those especially qualified. A general high school education or its equivalent is necessary, and college or normal training is desirable. The special requirement is that of technical training. Knowledge of at least one craft is essential, as well as the ability to teach the elements of one academic subject. Experience in social service, nursing, teaching playground work, physical training, or kindred subjects will make an excellent basis for development.

The course of training will include lectures and manual work in the crafts. The lectures cover the elements and history of occupational therapy and applied psychology, especially in relation to the various kinds of physical and mental handicap, and also include training in hospital routine and etiquette.

The work in the crafts includes woodworking, chair-caning and rush seating, basketry, cord work, clay-modeling, simple weaving, rug-making, dyeing, bookbinding, simple metal work, application of design, and practice teaching.

I borrow joy from sorrow—
A Rainbow from the Rain!
If life were not in Shadow,
My Star would be in vain—

—R. Valentine Heckscher.



DISPENSARY AND OUT-PATIENT WORK

Conducted by MICHAEL M. DAVIS, Jr.

Director of the Boston Dispensary.

Please address items of news and inquiries regarding Dispensary and Out-Patient Work to the editor of this department, 25 Bennett street, Boston, Mass.

CLINICS FOR VENEREAL DISEASE

I. Equipment for Separate Treatment of Syphilis and Gonorrhea—Adaptation to Small Hospital or Dispensary—Details and Approximate Cost of Furnishing Small Clinic

By MICHAEL M. DAVIS, JR., Director of the Boston Dispensary.

In a large out-patient department or dispensary, the clinic in which syphilis is treated may be separate from that dealing with gonorrhea; in fact, this separation is desirable whenever practicable. The equipment for the two diseases will be outlined in the following as for two separate clinics. A section relating to adaptation to small or large clinics will be appended.

1. Syphilis

"A syphilis clinic needs as good light as a dermatological clinic. There must be a history room, an examining room for each physician on service, and a special room for the administration of salvarsan. The staff must have facilities for Wassermann tests and a dark-field microscope for examination of primary lesions. The main laboratory of the dispensary may provide these facilities. In many institutions the Wassermann tests will be performed at the laboratory of the municipal or state department of health, but the clinic itself must provide for the diagnosis of early cases. The growing importance of lumbar puncture in the diagnosis of syphilis of the central nervous system renders it essential to have facilities for this. There is still some difference of opinion as to how far it is safe to perform lumbar puncture as an out-patient procedure, the patient going from the building shortly after the operation. Many clinics of standing have had excellent results and no serious drawbacks from the performance of lumbar puncture in this way. But some selections of cases must be made, and it is desirable to have facilities for keeping patients over night, although they need not be utilized for every patient."¹

2. Gonorrhea

"The equipment for the diagnosis and treatment of gonorrhea will include accessibility to a laboratory for examining smears and urine and making complement-fixation tests. Examining and treatment tables, with irrigators, sounds, catheters, dilators, bougies, etc., are necessary. The cystoscope is essential, and a special room and table for cystoscopy are desirable, though not necessary. Some genito-urinary clinics do a good deal of operating under local anesthesia and a special room for this, with operating and instrument tables, etc., will be required. Such a room may also serve for the cystoscopic work. The sterilizing equipment must be carefully looked up. Much the most convenient arrangement is to have the treatment room cut up into a series of small rooms, or booths, so that each patient has a room or compartment to himself during treatment. This compartment should preferably contain a small instrument sterilizer so that

each physician can have his instruments, gloves, etc., readily accessible. Much time is saved by such an arrangement, and privacy is gained. A utensil sterilizer for the basins, etc., is a necessity in the clinic. There must be a urinal immediately accessible, preferably within the clinic. A clinic providing for three physicians, treating men only, should have a trained attendant or clerk and, if possible, a male social worker, an admission or history room, two treatment rooms or booths with the urinal accessible, and a cystoscopy room. If women are also to be treated during the same clinic period, an additional history room, a treatment room and a nurse will be required.

"Gonorrhea in females is sometimes treated in the gynecological department. The sequelae and complications of gonorrhea closely involve the surgical aspects of gynecology. In some institutions, however, gynecology is combined with general surgery in the dispensary, and gonorrhea, as such, among both sexes, is received in the genito-urinary clinic."

3. Relationship to Other Clinics

I. SYPHILIS

"The great variety of local symptoms arising out of this disease cause patients with symptoms which are really the result of syphilis to appear in every department of a dispensary. For the sake of clinical effectiveness in diagnosis and treatment, and for the protection of the public health, it is essential that every dispensary lay down the rule that all syphilis be the responsibility of a single department. Whether this department shall be a special clinic for syphilis or a genito-urinary department treating syphilis and gonorrhea, or whether it shall be a department of dermatology and syphilis, is a matter for detailed consideration."

"The department where is placed the responsibility for the treatment of syphilis must depend on the oculist to help with an eye condition, the surgeon, perhaps, with a syphilitic ulcer, the medical clinic with a heart condition, the children's clinic with a difficult feeding case of congenital syphilis. The neurological department must have jurisdiction over its special manifestations of the disease."

"These general principles should be laid down: (1) Concentrate the responsibility for syphilis in a single department; (2) let its local manifestations or symptoms be examined or treated in those clinics to which they especially relate; but (3) require the patient to report for constitutional treatment at periodic intervals, as required by the condition, to the department having the general responsibility for syphilis. The department having the primary responsibility for syphilis will thus carry all syphilitic patients on its follow-up system, but some of the same patients will also be carried by other clinics. This relationship is particularly important in dealing with cases of neuro-syphilis."

"One means of enforcing these principles in practice is through the requirement that the Wassermann test shall be done only through a single department, e. g., the central laboratory, and that the occurrence of a positive Wassermann (or any other test which indicates syphilis) shall automatically cause a patient to be transferred to the department having the primary responsibility for syphilis, the patient being placed on the follow-up system of the syphilis department."

II. GONORRHEA

"If both men and women are treated in the genito-urinary clinic, the two sections must be kept administratively separate to a large degree, with separate waiting-rooms. If syphilis as well as gonorrhea is treated, the equipment and arrangement specified above must be included, and at least one additional room will be required for men and one for women. Assuming for the moment that only gonorrhea and the surgical aspects of genito-urinary diseases are included within the scope of this clinic, the following may be outlined:

"Gonorrhea is a disease which requires frequent visits and a fairly long period of treatment, and therefore the proportions of visits to new patients will be large. Even including those cases which are transferred to other institution, which move away from the city, seek treatment elsewhere, or which are 'lost,' the average visits per patient among gonorrhea cases should be between fifteen and twenty, and any lower figure should arouse question whether proper supervision and control of the disease is

¹ This and several following paragraphs, within quotation marks, are cited from "Dispensaries, Their Organization and Management," by Dr. A. R. Warner and the writer of this article.

exercised. This test must not be applied to a genito-urinary clinic as a whole, since a certain proportion, sometimes a large proportion, of the cases in the clinic are not gonorrhea. The chief of the clinic should see all new cases. In a large clinic the patient is usually assigned at the first or second visit to an assistant for treatment, if this is of a routine character; but the chief himself or a designated assistant would ordinarily attend to a case where the cystoscope was necessary. It is desirable that the chief, or a specially designated assistant, should see the patient at each revisit to note progress and indicate further treatment. The same physician thus sees the patient each time, even though a different physician may give the local injection, etc. The presence of a clerk or trained attendant to attend to records and details, care for instruments, the follow-up system, etc., is essential unless the clinic is a small one."

These principles of organization will be elaborated in the second article of this series on clinic management.

4. Adaptation to the Small Hospital or Dispensary

Conditions in the small hospital, located in a town of 25,000 or 50,000 persons, differ widely from those in a great metropolitan institution. Resources are much more limited, both as to medical personnel and as to equipment. Furthermore, in the smaller community there may be more sensitiveness on the part of patients in attending a clinic for venereal disease, because of the fear of meeting people they know. This difficulty is almost entirely obviated when the venereal clinics are part of an outpatient department in which other diseases are received. Such a policy is desirable in all cases.

The small hospital or the hospital of moderate size which is starting venereal clinics, may be assisted by the following detailed list of furnishings and equipment.

The expense of maintenance may be reduced to little or nothing if some or all of the clinics are made pay clinics. The initial expense need alarm no institution which has either funds or courage.

5. Furnishings and Equipment for a Small Clinic

I. ROOMS

1. Waiting room. The sexes need not be separated, providing the room is a public passage-way, or is under the eye of a nurse or clerk. If it is a secluded room, separate partitioned spaces or rooms should be provided for women and children.

2. An admitting or history room.

3. At least two examining and treatment rooms. Where more than two doctors are at work, there should be three such rooms, and it is a convenience to have three in any case, since the equipment for the different types of work can be better distributed. All these can be small rooms; 8 by 10 feet will do, or even 7 by 9 feet.

II. FURNITURE

The minimum requirements are (1) two writing tables or small flat-top desks (\$5 to \$10 each); (2) two examining tables, which had best be of white enameled iron (\$18), although more convenient and expensive adjustable tables can be purchased; (3) three small white enamel instrument stands (\$10 each).

In addition to the chairs or benches necessary in the waiting room, at least eight chairs for doctors and patients will be required in the clinic. If there are three doctors or three examining rooms, three examining tables and an extra instrument table and desk will be necessary.

III. STERILIZING EQUIPMENT

1. Instrument sterilizers; the common "fish-kettle" (\$2.50) to be used over gas will do, or an electric self-closing sterilizer costing from \$12 to \$20.

2. A dressing sterilizer (autoclave) is necessary, unless provided elsewhere in the hospital (cost \$150).

3. Utensil sterilizer, costing \$85 and up, is essential,

unless provided elsewhere in the hospital. If there are three doctors working, two instrument sterilizers will be desirable. Total cost of sterilizing equipment would be within \$260, and might be one-tenth of this if the hospital had the two larger sterilizers accessible. The instrument sterilizers must be in the clinic, anyway.

IV. MICROSCOPY, LABORATORY SUPPLIES AND ACCESSORIES

1. Microscope, \$85 plus.

2. Dark stage and illuminator, \$45.

3. Minor accessories for microscope, and simple equipment and chemicals for routine urine and bacteriological examinations, \$25. An electric centrifuge for the examination of urine is highly desirable, costing about \$50, but hand centrifuges, costing \$10 or \$15, can be made to serve.

V. SPECIAL EQUIPMENT FOR SYPHILIS

Apparatus for the injection of salvarsan and for the taking of blood for Wassermanns; hemostat, syringes, needles, basins, and instrument trays, Erlenmeyer flasks, glass graduates, total cost \$15 to \$20.

VI. SPECIAL EQUIPMENT FOR GONORRHEA

Instruments including sounds, bougies, catheters, dilators, syringes, irrigating stands, rubber gloves, tubing, finger cots, etc., about \$75 for the necessary sets.

A catheterizing cystoscope, with batteries, about \$85.

A cystoscopic table, costing about \$50, would be a convenience, but the ordinary flat examining tables can be used quite well.

No instruments for surgical work are included.

An instrument cabinet, made to lock, would cost from \$20 to \$50.

Stock of linen, cotton, etc.—\$25 would give a start.

VII. CLERICAL SUPPLIES

Equipment sufficient to provide for 2000 record cards would include index drawers for 3 by 5 cards, \$5; medical record card drawers for 5 by 8 cards, \$9; visible file of one of the two frequently used types, \$4 to \$12; cards properly printed for use in the follow-up system with the visible file, \$4 per thousand, if printed in quantity; medical record cards, printed, \$4 per thousand; 3 by 5 cards, \$3 per thousand; rubber stamps, date stamps, receipt and report forms, \$25.

VIII. MEDICINES

If there is a pharmacy in the hospital, these are readily provided. Otherwise, a special set of medicines will have to be purchased, compounded, and kept in stock. The usual medicines used in the treatment of typical, acute gonorrhea cost (for the materials) fifty cents to a dollar per week during the early stages (the retail drug-store prices are two or three times this sum).

IX. SUMMARY—(FOR A CLINIC USING ONE OR TWO DOCTORS)

1. According to local conditions.

2. Furniture: \$100 up, not counting benches or chairs in waiting room.

3. Sterilizing equipment: \$260.

4. Microscope and laboratory: \$165 to \$205 or above.

5. Special syphilis equipment: \$20.

6. Special gonorrhea equipment: \$230.

7. Clerical supplies: \$70.

Total: \$845 or above.

A hospital might well have, all ready to provide, part of the furniture and sterilizers, the microscope, chemicals, part of the special equipment for syphilis and gonorrhea, and the linen, etc. The cost of the extra equipment might then be only from \$200 to \$500. On the other hand, it would be easy and rather desirable to buy better things and make the foregoing list run to \$1,200.



Conducted by ANNIE W. GOODRICH, Dean Army School of Nursing and CAROLYN E. GRAY, Principal City Hospital School of Nursing, Blackwell's Island, New York.

Please address items of news and inquiries regarding Department of Nursing to CAROLYN E. GRAY, Principal City Hospital School of Nursing, Blackwell's Island, New York.

HOW THE COLLEGES CAN HELP IN THE TRAINING OF NURSES*

Affiliation of Training Schools with Universities Found to Be of Mutual Benefit—Emergency Preparatory Course Given at Vassar Camp an Unusual Success.

By ISABEL M. STEWART, R.N., A.M., Department of Nursing and Health, Teachers' College, Columbia University, New York City.

The war is bringing a great many changes in all branches of education—and none more interesting and significant than those which are taking place in the field of nursing education. Until very recently, nursing has been more or less a cloistered profession, and nursing schools have been practically isolated from all other systems of education. Nobody knew what we were endeavoring to accomplish in our training schools, and we did not know very much about what was going on outside our own very busy institutions.

Without financial resources, and without any of the machinery of a modern educational institution, we have been struggling on alone, trying to make the system of training established thirty or forty years ago in hospital training schools fit the rapidly increasing demands of a modern scientific and technical profession. Had we been more closely in touch with the currents of educational progress stirring in the world outside, we should probably long ago have done as so many other private professional and technical schools have done—we should have simply admitted that the job was getting too big for the individual hospital school and have asked to have part of the work taken over by public institutions which were better equipped to carry it on. In that way we should have secured, not only relief from our almost impossible task, but a far greater measure of understanding and appreciation of our work on the part of the great body of educators and the general public.

The fact is that the public has never realized the magnitude of the problem with which the hospitals have been struggling in the education of nurses nor has it grasped the relation which this training bears to the safety and welfare of the nation. There has been much criticism, but no real appreciation of the fact that the whole burden of preparing these workers for the service of the state and the community has fallen largely on private and philanthropic institutions, with no assistance at all from educational funds such as are appropriated for the training of teachers and other technical and professional workers. Millions of dollars of public money have been spent

on training students and teachers of agriculture, for instance, but not a cent has ever been given from the public treasury to promote the education of nurses. The reason probably is that, until we found ourselves nearly swamped by the problems of the war, we have never thought seriously of asking for public help, and we have not made our work and our needs known either to the public or to the educational institutions who might have helped us.

Our comparative isolation from other educational institutions and certain of the older features of our educational system have also made it difficult for us to attract into our schools very large numbers of highly qualified students such as those who are found in the colleges and the institutions of higher education in this country. This seems strange, considering the remarkable development of the nursing field in recent years and the quite unusual opportunities for well educated women in many important branches of nursing service. College women have been flocking into business and industry and into many other new fields which do not compare with nursing in social importance or human interest. They have often expressed great interest in nursing work, but, after inquiring about the length of training, the small amount of time given to study, the long hours of hard practical work, and other conditions of hospital service, they have hesitated and very often have chosen other less attractive vocations.

Long before the war, however, certain steps had been taken to secure a closer cooperation between nursing schools and universities, so that a sounder basis could be established for the training of nurses. There was never any idea of extending this system to all schools of nursing, but there was a hope that in this way we might select and prepare a larger number of thoroughly qualified women to serve as teachers, organizers, and executives in the higher branches of professional work. We have always been pretty well supplied with rank-and-file workers in nursing, but we have been expanding so rapidly that we have never had nearly enough competent leaders and officers, and our hospital and public health work has often been seriously crippled by this deficiency.

These efforts in tying up our work with higher educational institutions have been on the whole very successful. Nursing courses of a number of varied types had already been established in about sixteen colleges and universities, and the movement was slowly but steadily taking root. There was, however, little or no prospect of any immediate or general readjustment in our system of training. The colleges were wrapped up in their more purely academic interests, and, not being closely in touch with actual conditions among the great masses of our citizens, they did not clearly grasp the vital importance of the work which nurses have been doing in many branches of public service. The hospitals were on the whole satisfied with things as they were, or were inclined to endure the evils of which they knew rather than to fly to others of which they knew not. Both are extremely conservative institutions and not likely to take such a radical step without some special push.

Then came the war. It is a well-recognized fact, drawn from the history of hundreds of years, that, whatever the devastating effects of war may be in other fields of activity, its effects on medical and nursing work have usually been highly beneficial. Indeed, the great periods of progress and reform in nursing and hospital work have practically always followed as a result of the experiences of war or some other national calamity. In the first place, just as the thought of war fires the fighting instinct in men, so the suffering of war and the wholesale de-

* Read before the Twentieth Annual Convention of the American Hospital Association, Atlantic City, N. J., Sept. 24-28, 1918.

struction of human life quickens the nursing instinct in women. Whatever may have been their previous pursuits and interests, they see at once that this matter of conserving human life is the fundamental thing, and many of them are willing to throw aside years of training in other fields to help in the only thing that seems really to matter, the relief of suffering and the saving of lives. Of course, a number of those who are clamoring to do "war" nursing are of the emotional, sentimental type, but a substantial proportion are fine, wholesome, intelligent girls and women who, when they see the need, are willing to do anything to prepare themselves for real service.

Among the very first to volunteer for nursing work were great numbers of college women, and the question was how we could make the best use of their excellent previous preparation and their known qualities of leadership in organizing the great new nursing army which must be raised to meet the needs of the military and naval service. The army and navy were drawing heavily upon the men's colleges for officer material, and it seemed to be quite the fitting and logical thing that the women's colleges should supply at least a fair proportion of the women who might be prepared to train the new recruits and to help in organizing and directing nursing work in both military and civic hospitals.

The National Committee on Nursing felt it necessary, in view of the urgency of the situation, that such students be trained as rapidly as possible; so arrangements were made with a number of representative hospitals to give credit for previous college training and push these students through in about two years instead of three. A general appeal was then sent out to the colleges to urge their students and graduates to enter at once for the nurses' training on this basis. The appeal met with a very cordial response. The need was so evident and the desire for real practical service was so keen that a considerable number entered last summer, several hospitals arranging special summer preparatory courses to let them get started at once.

But the colleges were not satisfied simply to send their students into hospitals. They began to inquire whether they could not do something more to help, and several of them in their zeal made the mistake of thinking that they could themselves prepare their students by short theoretical courses to go to the front as "war" nurses.

The trustees and faculty of Vassar college were exceedingly anxious to use their great plant and its many educational resources during the summer to further war preparedness in some definite way and, in looking over the whole field of women's work, decided that nursing was the most important and the most immediately necessary branch of women's service in war. The idea of a summer preparatory course in nursing for college women was suggested by the summer military training camp at Plattsburg for men. Mrs. Blodgett, one of the Vassar trustees, immediately consulted with Miss Nutting, chairman of the committee on nursing of the Council of National Defense, and was assured that the idea was an excellent and practical one. It was formally approved by this committee and by the Red Cross, the latter organization assisting substantially in financing the course as an experiment in war service training. A committee was appointed from the National League of Nursing Education to help in working out the curriculum, and the National Committee on Nursing gave constant advice and assistance in developing the other features of the plan.

The experiment all through has been a great success. The idea of the nursing-preparatory course outside the training school was not in itself new, but it had never

before been carried out on such an extensive scale, with so many hospital affiliations and with such a highly selected body of students. The total number of students taking the Vassar course this summer was over 439. They are all graduates from colleges of good standing, 115 colleges being represented in the whole group. They come from practically every state in the country with a small group from Canada. Their ages range from 19 to 40 years, the mean age being between 24 and 25 years. They represent a wide variety of occupations, but over one-half of them come from the teaching profession, which gives some hope of relief for our serious scarcity of instructors in training schools.

They are a splendid body of women. The members of the faculty who have been working with them, as well as the superintendents of nurses, physicians, and college professors who have visited the classes and seen the students at work, all agree that they are an unusually keen, earnest, hard-working and attractive group of young women. They compare very favorably with professional students in any field, and most of them would be a decided asset in any profession.

One could not fail to be impressed with their fine spirit. It showed itself in the way they buckled down to work, in their ready acceptance of the strenuous program and somewhat restricted personal liberties which were considered necessary for the accomplishment of the work, in the cheerful way they rose for setting-up exercises at 5:50 a. m., and the zeal they showed in making envelope corners and wielding damp dusters. No doubt, there will be some in the group, as in all groups of probationers, who will fall down in their practical work, some who will prove "quitters" or "slackers," and some who will never be able to adapt themselves to the exacting demands of the hospitals; but, on the whole, most of them give the impression of being the kind of people we like to see coming into nursing schools—wholesome, intelligent, eager, energetic, and full of the spirit of service.

The course was arranged pretty much on the lines of the regular four-months preparatory course given in the better hospital training schools, except that there could be no practical work with patients in the three months while the students were at the college. The theoretical work was more intensive during this period, covering all the usual preparatory subjects—anatomy and physiology (60 hours), bacteriology (48 hours), chemistry (48 hours), hygiene and sanitation (30 hours), elementary materia medica (24 hours), nutrition and cookery (60 hours), elementary nursing and hospital economy (60 hours), and the history of nursing (10 hours). In addition, students who had not had college courses in psychology and social science were expected to take the elective courses in these subjects of 30 hours each. A number also elected the course in physiological chemistry, which was offered for those who had already studied general chemistry.

The students had practical, as well as theoretical, work in elementary cooking and nursing procedures in the college laboratories, which were well fitted up for the purpose. Though they could not be trained in the exact methods of the different affiliating hospitals, they did cover most of the practical work given in the ordinary hospital preparatory courses, and it was expected that they would require only a few demonstrations in the hospital's own methods to enable them to go ahead with the regular work in the wards. They entered the hospitals on the status of probationers in the beginning of the fourth month of training, the only difference being that their theoretical work was already covered and that they would be expected to spend the last month largely

in intensive practical work under the careful supervision which all probationers require. At the end of this time, they will be given their uniforms (if accepted) and will proceed at once with the remaining work of the junior year. Since they are all entering for the two-year course, their theoretical work of the intermediate and senior years will have to be combined and the periods of experience in the different services somewhat shortened to provide for the usual all-round training.

The arrangements with the affiliating training schools have, on the whole, worked out satisfactorily. It was considered wisest to concentrate the students in a few hospitals rather than to distribute them over a great many. A number of representative schools of various types were selected from various parts of the country, connected with hospitals with good clinical facilities, good traditions of nursing work and good standards of instruction. These schools were invited to cooperate with Vassar College on the basis outlined above, and most of them accepted gladly, stating the number of students they could take. A number of the prominent schools of the country were not included in the final list, as they were not able to reduce their three-year course of training either on account of state laws or because they preferred not to make any change in their system. Wherever any hospital asked to have its nursing school included in the list and gave some assurance that it had the facilities for giving a good training, it was added, unless, as in some cases, the application came too late.

Students had absolute freedom of choice in the selection of their schools, except for the fact that the better-known schools in the list were quickly filled up and consequently a second, and sometimes a third or fourth, choice had to be made. Whenever any student expressed a preference for a school not on the list, she was at perfect liberty to enter that school if it proved to be of good general standing.

A copy of the Vassar application blank, which included a statement of the student's educational qualifications, physical condition, and other information of a general character, was sent at once to the first training school selected, and the superintendent of nurses accepted or rejected the student as she would any other applicant. If rejected, the blank was sent to the school of second choice and so on. Dean Mills, who has shown from the beginning an unusual appreciation of the hospital side of the problem, has strongly discouraged any changing about, once the decision was made and the student's application accepted. Practically all the arrangements were made before the new Army School was established; so very few are entering the military hospitals.

The results show a decided preference for hospitals located in the larger eastern cities, particularly in New York. By far the largest groups go to the big municipal hospitals like Bellevue, New York, which took about sixty, the City Hospital, New York, the Philadelphia General, the Cincinnati General, and others of the same type. It seems evident, therefore, that, if most cities or states wish to secure such applicants for their own schools, they will have to establish their own preparatory courses and connect up with the local hospitals.

Many very interesting features of the Vassar course might be described, but it will be of special interest to hospital people to know the efforts which were made to prepare the student for the life and duties of the hospital. In all the courses, but especially in the laboratory work in the sciences, cooking and nursing, definite attention was given to training the students to observe details, to use their hands, to plan ahead, and to be systematic and

orderly in their work. To help in establishing good personal habits, they were all required to make their own beds, to dust and tidy their rooms, and to keep their dormitories in a neat and sanitary condition. Regular room inspections were made by the nurses on the faculty, and records were kept of the students' standing on these and other matters relating to dress and deportment. Students were required to wear the uniform of the school to which they were assigned, and high-heeled shoes, extreme coiffures, jewelry, and other small vanities were gradually eliminated. Hospital hours for rising and retiring were enforced, and some of the commoner observances of hospital etiquette were observed.

Undoubtedly all these things contributed to the splendid morale of the students, but the main thing was that they were exceedingly happy in their work and in their personal relationships with their instructors and the many other officers of the camp. Their living conditions were good, their health was very well looked after, excellent provision was made for sports and other athletic activities, and the social life of the whole large family was exceedingly pleasant.

Besides the inspiration which a large group like this gets from starting in together, there is the great advantage of being launched into their future work with a certain impetus and enthusiasm. Most nursing students who drop out during the early stages of the hospital course do so because they fail to catch the meaning of the whole thing—they do not clearly see the goal which lies at the end of the long up-hill climb. It was interesting to see the gradual change in the view-point of these students, the rising appreciation for their new vocation which followed the various talks by leading men and women in nursing and health work. Many of the Vassar group had entered with the idea of going back to other lines of work after the war, but, unless their present enthusiasm becomes chilled sadly, there is every reason to believe that most of them will stay in the profession in educational or public health work.

There has always been a question as to whether instructors who are not themselves nurses or physicians connected with a hospital would be able to bridge the gap between the class-room and the hospital ward and make their teaching really practical and effective. The larger number of professors and instructors at Vassar this summer were recruited from the many different colleges. Most of them were not doctors or nurses, and indeed many, to begin with, had very little knowledge of special nursing needs. But they were highly trained specialists in their own branches and, with some help from the nursing and medical members of the faculty, they very soon found out what subjects needed emphasis and what kind of applications would be most helpful for these students. With the exception of practical nursing, materia medica, and the history of nursing the main part of this work can probably be better handled on the whole by expert teachers of bacteriology, chemistry, hygiene, dietetics, etc., than by the busy practicing physician or the nurse instructor in the hospital, who is usually expected to cover a dozen different subjects. The main thing is that they should be interested enough to make a special study of the phases of nursing to which their subject specially applies and that they should be good teachers in sympathy with this group of students. The teacher of practical nursing will then be responsible for connecting up the various sciences with the practical problems of the hospital, thus unifying the whole body of knowledge and making it more concrete and practical.

Although many modifications will probably have to be

worked out later, and although it would not be possible or desirable to carry out all the features of the Vassar Training Camp under other conditions, there is no question but that this plan offers a good practical basis for cooperation between colleges and nursing schools. Four other courses of a somewhat similar type were carried on this summer as a result of this suggestion and many other colleges, universities, normal schools, and technical schools are inquiring about the possibilities of working out the same kind of an arrangement in different parts of the country.

The American Council on Education, in cooperation with representatives of the Committee on Nursing of the Council of National Defense, the Army School of Nursing, the Vassar Training Camp, and the Association of Collegiate Alumnae, is taking up the whole question with a group of selected colleges, and is ready to push ahead with plans and arrangements as rapidly as possible. A pamphlet,¹ outlining the general principles on which the work should be developed, has been issued by the Committee on Nursing of the Council of National Defense, Washington, D. C., and this may now be secured by any one interested in the subject.

The main arguments for the nursing preparatory course in the colleges are:

1. It will relieve some of the pressure on hospital training schools during the war. On account of additional classes and depleted staffs, it has been almost impossible to carry on proper teaching in many schools and yet the need for this work was never more urgent and imperative.

2. It will relieve the hospital of the most expensive and difficult part of the nursing course, and the students who enter will be better prepared to start at once on their duties in the hospital. The poorer ones will be largely weeded out before they come to the hospital.

3. A thorough, intensive course of preliminary instruction will give a sounder preparation for future nursing work, and it is hoped that, on this account, it may be possible to push students through a little more rapidly.

4. By connecting with an academic institution of recognized standing, a better class of women will be attracted into nursing schools, and much larger numbers can be recruited for the special needs of war time, as well as for the permanent field.

5. It will release additional housing accommodation in the nurses' home and so make it possible for the hospital to take in and train more nursing students for its own and the country's use.

It is not at all necessary that students should be college graduates, but they should have good high school training. It would be essential, of course, that the educational institution offering such work as this should be of recognized standing, and the training school authorities should be quite satisfied that the instruction and conditions of work are of the right kind before making any arrangements to turn over their preparatory work. Unfortunately, a few institutions have already ventured into this field without consulting any recognized representatives of nursing schools and without knowing anything about the standards of good nursing training. Such courses will undoubtedly attract numbers of misguided people, and even training schools may be misled into recognizing their work if this is not made perfectly clear.

The main thing which must be absolutely insisted upon

¹Preparatory Courses for Nurses in Colleges and Universities—A War Measure.

²A copy of this curriculum can be obtained by sending one dollar to Miss Isabel M. Stewart, Department of Nursing and Health, Teachers' College, 525 W. 120th St., New York City.

in any course of this type is that it must be worked out in the closest cooperation with recognized representatives of the nursing profession and in harmony with the standards which are generally accepted in the best nursing schools. This is particularly important when it comes to the selection of affiliating schools. It is suggested that the general standards outlined in the Standard Curriculum for Nursing Schools² published by the National League of Nursing Education, would be a fairly reasonable requirement for such schools, or something approximating such a standard. In war time, of course, conditions in even the best hospitals are not normal, but, if training schools could be released from even a part of the preparatory period of training, it should be possible for them to concentrate more on the rest of the course and thus give a good all-round training.

In some places affiliations with colleges are also being made in the latter part of the third year, for students who wish to specialize in teaching or in public health nursing. This is another plan which is being pushed ahead because of our war needs and which will probably be worked out more fully during the coming year. All kinds of conditions are changing under the stress of the great emergency, and no one can foresee the adjustments which may have to be made from day to day and month to month. Some of these will be temporary, but it is probable that out of our new experiences we will be able to build something which will carry us forward a long way toward a more ideal system of nursing education. The great thing for us now is to hold ourselves open to every new suggestion which will help in getting many thousands of trained women into the field at the earliest possible moment and to utilize every agency which will help us toward that end.

* * * *

SUMMER PREPARATORY COURSE FOR NURSES GIVEN AT WESTERN RESERVE UNIVERSITY*

Steps Taken in Establishment of Course—Outline of Curriculum—Advantages and Disadvantages

By CLARIBEL A. WHEELER, R.N., Principal, Mt. Sinai Hospital School of Nursing, Cleveland, Ohio.

The preparatory course for student nurses given this summer at Western Reserve University originated in the mind of the president of that university, who, interested in the education of nurses and reading of the course being planned for Vassar College, wished that something similar might be accomplished at Western Reserve. This desire became known to the League of Nursing Education of Cleveland, with the result that immediate interview was sought with the college president and in the twinkling of an eye the project was launched.

It was not deemed advisable or practical to open the course to college graduates exclusively, as Vassar was recruiting college women from all over the country for the course to be given there; consequently a plan on a much smaller scale was decided upon. The minimum entrance requirement was made a high school diploma, and students were recruited for schools of nursing of Cleveland.

A committee from the League of Nursing Education, in conference with members of the faculty of Western Reserve University, planned the curriculum and acted as an advisory board for the course, a director being appointed to manage the details.

*Read before the Twentieth Annual Convention of the American Hospital Association, Atlantic City, N. J., Sept. 24-28, 1918.

The greatest obstacle that lay in the way was the financial log. How were we to meet the expense of such a course? An appeal was made to the Mayor's War Advisory Board of Cleveland, who recognized the value of such a course as a war measure and graciously appropriated the necessary funds.

Instructors were secured from the faculty of Western Reserve Medical College, Adelbert College and the College for Women, with the addition of two nurse instructors from Cleveland schools of nursing.

Students were recruited directly through the university, which announced the course in their summer school bulletin, and through recognized schools of nursing of Cleveland. The nursing section of the woman's committee of the Council of National Defense gave valuable assistance with the recruiting. The Vassar recruiting committee also referred to us applicants who did not meet their requirements or who were too late for registration in the Vassar course.

It was impossible to give the course publicity until after the first of May, when arrangements had been definitely made. In spite of this fact, a large number of applications was received. It was impossible, on account of lack of facilities, to take more than one hundred students. Consequently, one hundred applications were accepted, and eighty-eight of this number reported for registration.

The course, which opened June 17 and closed August 24, was given in ten weeks and was divided into two terms of five weeks each. During the first term, lectures were given at the Medical School, and during the second, at Adelbert College.

Students were required to select the Cleveland school which they desired to enter and were assigned to that school at the time of entrance. The hospitals provided room, board and laundry during the ten weeks. The students lived under the same regulations as the other pupils in the school. Uniforms were not worn, as many had to go considerable distance through the city to classes. Each student paid for all text books, laboratory fees, car fare, etc. Those who were not affiliated with any school of nursing in Cleveland were required to pay a tuition fee of \$25 and to meet their own living expenses.

The students were a bright, enthusiastic, patriotic group of young women, mostly fresh from school or from teaching. Seven of them were college graduates; two had completed three years of college; four had finished one year of college; one was a normal school graduate; seven had taken several years of normal work; and the remaining sixty-seven were high school graduates.

Of the eighty-eight who entered, eighty-three were assigned to hospitals, four to army schools, and one expected to enter an out-of-town school. Eleven dropped out for various reasons before the completion of their ten weeks. The others are now being given intensive training in nursing theory and ward practice in the hospitals, where they have the status of probationers in their third month.

The subjects given were: anatomy and physiology, 75 hours; bacteriology, 45 hours; chemistry, 30 hours; drugs and solutions, 30 hours; history of nursing, 15 hours; household economics, 30 hours; hygiene and sanitation, 20 hours; nutrition and cooking, 45 hours; sociology, 10 hours; total, 300 hours.

On account of limited time, principles of nursing and procedure was not given. The cost per capita of the course was about \$40, not including any of the expenses borne by the students themselves.

Centralization of schools for preliminary preparation of nurses is a thing to which we are looking forward. The

summer courses given at Vassar, Western Reserve, and several other colleges seem to be the beginning of such a movement. A discussion of a few of the advantages and disadvantages as demonstrated in our course at Western Reserve may not be out of place in this report.

The disadvantages are easily discernible:

1. The crowding of so much theory into so short a time is one of the greatest. The instructors all made this criticism, saying that it was impossible to do justice to their subjects. It is also a question whether science taken in such large doses will be properly assimilated, especially by pupils who have high school training only.
2. For the students who came directly from a school year of hard mental work the heat of summer was difficult. It is doubtful if they did the best work of which they are capable.
3. The students were greatly handicapped by having to travel considerable distance to classes, thus losing valuable time.
4. It was also a disadvantage having the students so separated and living under different regulations and discipline in the different hospitals.
5. The last two difficulties were ideally met at Vassar by housing the students in dormitories on the campus, where they were all under the same regulations and living conditions.

The advantages are obvious:

1. As a war measure, it was most successful, for it supplied to the schools of nursing of Cleveland an extra class of students.
2. It relieved all the hospitals of one of their greatest burdens, that of the cost of instruction.
3. The students had at their disposal the splendid facilities of the college laboratories, which are far superior to any found in hospitals. For example, the anatomy and bacteriology laboratories at Western Reserve Medical College, with their wealth of material, offered advantages which could not be equalled.
4. Instruction was given by expert teachers, who were especially interested in nursing education and who endeavored to correlate their subjects to nursing.
5. The fact that the course was given in connection with a large university attracted a group of intelligent, patriotic women.
6. Reports are being received that these students are doing unusually good work and that their knowledge of bacteriology, hygiene, household economics and history of nursing has provided them with a real background for which they are undertaking and has given them a greater appreciation of the conditions which they are meeting than has been evinced by those who have received this grounding later in their course.

The results on the whole are pleasing; the conclusion is, therefore, that the idea of centralization for preliminary preparation is not an erroneous one and that the establishment throughout the country of longer and more permanent courses of this character is desirable.

Abstract of Discussion

MISS MAUDE LANDIS, New Haven, Conn.: The Connecticut Training School is one of the oldest training schools, having been established under a separate charter in 1872. During the past few years it has begun a systematic development, assisted by the Yale Medical School and the New Haven Medical School, which has necessitated a new organization. The Yale Medical School has recently been very richly endowed, and it was, of course, necessary that additional facilities be added to the hospital. The Connecticut Training School is the nursing department that has to do with the care of the sick in the New Haven Hospital, and the hope is that it will be the department of nursing of the Yale University. This is a peculiar situation, for Yale University is not a co-educational school. The only women who attend Yale University are the graduate students, and, as the requirements for entrance into training schools are not of post graduate qualifications, exceptions have to be made for these students. Yale Medical School does not care to assume the financial responsibility attached to making the training school one of its departments. It is, however, quite willing for the training school to go in as a department of Yale University, and we are looking forward with very great interest and anticipation to the result of this affiliation. Some publicity has been given to the plan, calling attention to the nursing needs, and this, together with the popularity won by nursing during the summer, has made it possible for us already to raise our entrance standards. The curriculum, as we have outlined it, partakes very much of the content of that given at the summer course at Vassar. We have within our call the instructors in the various departments at the university; so the course contemplated for our nurses is going to be quite wonderful. What was given in three months or thirteen weeks at Vassar we will not try to give in thirteen weeks in our school, because we will have the practical coordinating with theoretical work.

The interest shown by everybody has made it quite possible to effect changes which, perhaps, at other times, or without this friendliness, would have been quite impossible. The hospital has a capacity of 275, with the

usual number of services in a general hospital. We have just 100 nurses, but, as time goes on, we see no reason why we cannot have the full quota, which would be about 130 nurses for that school. We have, aside from the university instructors, our own training school instructor and two practical instructors. We plan not only to have the theory well taken care of, but also to outline just what might be taught in the different wards and then have the head nurses responsible for all the instruction that their wards give. The few head nurses we have, have been employed with this in view. The correspondence has brought out that always—that they have a teaching responsibility—and, in that way, perhaps, there will not be undue attention given to the theoretical phase of our work.

Only a Scrap of Paper—But, Oh, What it Means!

Englishmen can hurry with a skill and an efficiency that takes even an American's breath away. When it comes to their fighting men they break all speed records. Thousands of men have died in the mud of Flanders—thousands have been wounded and sent home—but thousands have had to lie in those "Halls of Glory," the base hospitals behind the lines; and suffer—beyond the conception of any man—before the tide turns back towards life, or slips out in the gray dawn of Flanders, never to flow back. And the British fight to save those suffering men just as stubbornly as they fight to beat the enemy beyond the heavy cannonading a few kilometers away. As these men suffer and fight for life in the long white wards, they need so many things to help; and often it is just someone they love to touch, to smile at, to take hold on life once more—to wake up after moaning intervals of unconsciousness and find her sitting close to the narrow bed, smiling at you—and it is done just as quickly as that.

After the doctor's rounds, he sends a telegram asking her to come to such-and-such a base hospital to see Private ——. That very evening, perhaps, in Devon, where the sun sinks low, a small boy comes running and puffing up the lane waving the precious paper; the door under the thatch stands open. She is there, waiting, as the women are waiting the world over today and the message says "Come." That is all she needs—that telegram is passport, railroad ticket, bus-fare, channel crossing, entrance to the war-zone, space on troop-train, pass into that long, low building where her "love lies bleeding."

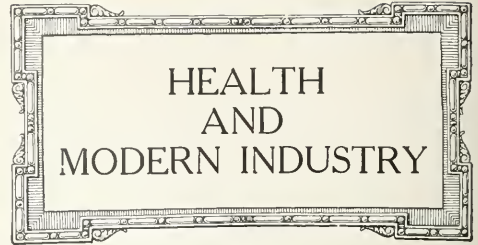
Yes, it's a wonderful high-way the British build from the aching ward in Flanders to the cottage in Devonshire. Just a telegram—no bewildering officials, no hours of waiting outside important doors—just a telegram; and the next evening at sunset, she is sitting by her man in Flanders as he sleeps for the first time because the tide has turned.

Just a thin bit of blue paper—just a telegram.

JUNE RICHARDSON LUCAS.

St. Cloud is one of the most efficient Canadian hospitals in France; it was given by the Canadian Government for the treatment of French poilus, and is under dual control. The French Government supplied the huts and the Canadian Government furnished them. Each hut is named after some province or city in Canada. Each hut averages twenty-eight beds, and 60 percent of the staff is French-Canadian, while the full staff numbers 223. The officer in command is Lt.-Col. Casgrain, of Windsor, Ont.—Hospital World, Toronto.

Go through your ward about 2 o'clock in the morning and put an extra blanket on the seemingly restless patients. Notice how quickly they settle down to sleep again.—Marie Robertson, R. N., in *The Nurse*.



Conducted by BARROW B. LYONS

Superintendent Delaware Hospital, Wilmington, Del.

ORGANIZED PREVENTION OF SICKNESS

How the Dennison Manufacturing Company Keeps Its Twenty-three Hundred Employees in Good Working Condition

By J. J. WEBER, Associate Director, Boston Dispensary, Boston

To hospital executives and workers in the health field generally, the city of Framingham, Mass., is far-famed as the seat of the community health and tuberculosis demonstration now being carried on under the auspices of the National Tuberculosis Association. To the public at large—the users of tags, pasters, Christmas seals, paper napkins and fancifully decorated crepe paper table cloths—Framingham is known as the home of the Dennison Manufacturing Company, "The House of Ten Thousand Articles." Neither the public at large, however, nor the health workers, generally speaking, are familiar with one of the most interesting and vital departments of this manufacturing establishment—the department of industrial service. This department is being built up as part and parcel of a going concern solely because the management is convinced that its activities make for efficient production. If time and money are being profitably spent in maintaining the integrity and prolonging the life of the machinery of the plant, surely, arguing *a fortiori*, time and money should be spent in maintaining the well-being

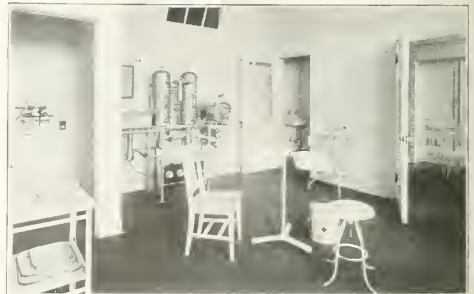


Fig. 1. The treatment room of the Dennison Manufacturing Company, with the coryza room, equipped for the treatment of head colds, at one side and the gargle room at the other.

and promoting the efficiency of the more important factor of production—the worker.

The industrial service department of this concern, now employing twenty-three hundred workers, is presided over by the Industrial Service Committee, made up of the treasurer of the company, the physician in charge of the medical clinic, the employment manager, the educational director, the registered nurse and the manager of the lunch

room. Various lines of activities are carried on, including educational classes, recreational activities, a rest room for women employees, a lunch room and a boarding house for girls. This article, however, will confine itself to the department's activities in the interest of the health of the workers.

These activities, of course, include the customary first aid and care of minor injuries and illnesses usually found in any manufacturing plant providing medical service for its employees. Anywhere from forty to sixty of the twenty-three hundred employees visit the clinic daily to have a slight cut bandaged, a toothache relieved or a slight cold treated. But this medical care, important as it is in relieving suffering, is quite subsidiary to the main



Fig. 2. The women's rest room of the Dennison Manufacturing Company, where employees are allowed a half hour's rest without loss of pay.

purpose of the company's health work. That purpose and controlling principle is the prevention of disease and the safeguarding and promotion of health. What are some of the ways in which this principle finds practical application?

In its medical work the industrial service department is not content merely with treating a wound, but every injury, however slight it may be, is reported immediately on a standardized blank form to the safety engineer, whose single task is the safety of twenty-three hundred workers. It is his responsibility to devise safety appliances that will prevent the repetition of accidents. Tangible evidence of his ingenuity may be seen on every hand by anyone whose privilege it is to visit the plant. The character of the products of the Dennison Manufacturing Company are fortunately such as to present few health hazards. The principle danger is probably from lead poisoning in the printing establishment, but here the hazard has been reduced to a minimum by the installation of efficient devices. Whenever, moreover, a new workman enters the printing department he is given a card telling him how to prevent lead poisoning.

PRECAUTION URGED UPON THE WORKERS

The employees are taught not to regard the common cold lightly, but are urged upon the slightest symptom to see the physician at the clinic. For the treatment of head colds a small anteroom, just off from the treatment room of the clinic, was built and equipped for aiding in the treatment of such colds by the inhalation of vapor rising from a pint of steaming water into which a teaspoonful of formaldehyde has been placed.

The preventive work of the department is further emphasized by the fact that curative work is done only where brief treatment is called for. When an employee's condition requires prolonged treatment, he is referred to

his own physician, to the out-patient department of one of the Boston hospitals or to one of the hospitals in Framingham. The company has no contract arrangement with any of the hospitals in Framingham for the medical care of its employees. It is, however, free to refer to them any of its employees requiring hospital care. Employees who come to the company's clinic complaining of trouble with their teeth are given temporary relief and an effort is made at once to arrange an appointment with the employee's dentist.

Another important aspect of the preventive work is the sanitary inspection made every week by the doctor and the nurse. Weekly rounds are made of all the toilets, wash stands, and dressing rooms. The floors of all of the buildings are carefully inspected and all insanitary conditions are reported immediately either to the cleaning department or to the sanitary engineer.

Unremitting effort is made to educate the employees in the fundamental principles of good health. Each year a little booklet, giving in simple language the laws that should be observed to maintain good health, are distributed among the employees. As one of the principal products of the company consists of tags of every sort, there is especial appropriateness in which the physician in charge of the clinic is now working out for the distribution about once a month of health tags printed in different colors. These tags will deal simply with such subjects as general health, head colds, care of the teeth, tuberculosis, proper posture, and safety first. The subject matter of the first tag will illustrate the character of this health propaganda.

1. Eat plain, wholesome food and eat slowly. The more your teeth work the less your stomach will have to do.
2. Drink plenty of water.
3. Get at least seven or eight hours of sleep.
4. Bathe the body at least twice a week with soap and warm water.
5. Avoid constipation, as free action of the bowels is necessary daily.
6. Brush the teeth twice daily, using some good dental cream. If your teeth need attention, see a dentist at once.
7. Avoid spitting; it is filthy and spreads disease.
8. Use the bubbling fountain for drinking, but do not touch the metal.
9. Have a complete physical examination by a doctor at least once a year. "An ounce of prevention is worth a pound of cure."

Every precaution is taken to prevent the spread of contagious disease among the employees. Any employee who has a contagious disease is not permitted to return to work until he or she has first been seen by the physician in charge of the medical work at the plant.

In its preventive work, the company has not as yet adopted the policy of having a physical examination made of all its new employees or of having periodical medical examinations of all of its old employees. An effort, however, is being made to persuade as many employees as possible to have a thorough physical examination made; and thus far two or three hundred of these examinations have been completed. A thorough physical examination is given all employees who are assigned to heavy work and all young men and women who are of working age, but under sixteen, are also examined when first employed.

REST ROOM AN IMPORTANT FEATURE

One of the outstanding preventive measures adopted by the company is the provision of a rest room for women

employees. This is a spacious, comfortably furnished room located just opposite the clinic. There are a dozen couches scattered about the room where women may rest during working hours or during the lunch hour with a measure of privacy through the use of movable screens. Electric warming pads are available. Employees using the room must first report to the nurse in charge of the clinic and are allowed one-half hour without deduction of pay. Ordinarily the room is used by from thirty to fifty employees a day and during the extremely hot summer months, by as many as one hundred and twenty to one hundred and thirty. This privilege is seldom abused and in a few instances where it is, a word from the nurse usually stops the abuse.

The Dennison Manufacturing Company is fully abreast of the times in its recognition of the important part which wholesome food plays in the maintenance of sound health. Most of the employees live near enough to go home for their mid-day luncheon, but such as are unable to do so are not left to the mercy of cheap lunch rooms. The company provides lunch daily for about six hundred and fifty of its employees, two-thirds of whom are girls and women. A trained dietitian is in charge of this department and every effort is made to provide wholesome, well cooked food at cost. Thus far, however, no effort has been made to suggest well-balanced diets nor are employees taught the relative value of various foods.

As eighty percent of the plant is now devoted to government work, and some of it has to be rushed, certain departments have night shifts. The physician is not on duty at night, but is subject to call in case of real need. Through a series of lectures the night foremen have been instructed in the use of first aid equipment.

All of this health work radiates from the medical clinic, an attractive, sunny suite of five rooms, including a large reception room where the doctor or the nurse receives the employees who come for advice or treatment, a well-equipped treatment room, the private offices of the doctor and the nurse and a small rest room for men employees. The treatment room, as will be seen from the picture accompanying this article, is adequately equipped with sterilizers, medicine cabinet and other necessary facilities. One of the special features of this room, the corzya room for the treatment of head colds, has already been referred to; the other special feature at the other side of the treatment room is the gargle room. The wash stand in this room is equipped with a special funnel-shaped glass receptacle leading down into the drain pipe, which prevents spattering when the gargle is spat from the mouth. Sterilized cups line one shelf, and a second shelf is provided for cups that have been used.

The medical work is in charge of a graduate physician, aided by a registered nurse, whose especial care is the health of the girls and women employed in the plant.

A Practical Health Guide

An interesting four-page pamphlet entitled "What To Do To Become Physically Fit," prepared by Surgeon-General Rupert Blue, has been published by the United States Public Health Service. Its intent is to furnish "Information for Those Disqualified for Active Military Service Because of Physical Defects," but it is a practical health guide to any man physically fit or unfit. It would pay any employer of labor to place one of these pamphlets inside the pay envelope of each of his employees.

Copies of the pamphlet may be obtained at small cost from the Superintendent of Documents, Government Printing Office, Washington, D. C.

ENLIGHTENED SELF-INTEREST OR SERVICE?

How and Why One Shipbuilding Corporation Immediately Cared for Its Employees and Their Families in the Recent Influenza Epidemic

BY THOMAS L. LEE HERSEY, Service Manager, Pusey & Jones Company, Wilmington, Del.

[NOTE: The following story of immediate and intelligent action on the part of an industrial concern is printed, not because it tells of something unusual, but because it gives a very frank statement which illustrates the value of welfare work, not only in emergencies but at all times.

—EDITOR.]

When it was evident that the influenza epidemic was seriously endangering the operation of our plant, we at once took action to care for our employees. As we are engaged in building ships for the government, it was essential that no more time should be lost than necessary.

We at once organized a relief committee. Wilmington was divided into zones, and the members of our firm owning automobiles volunteered the use in order that we might determine how many sick employees we had in each zone. Volunteer workers visited every employee who did not report for duty and brought in reports to the central committee each evening. The patients were reported as needing a doctor or a nurse or needing hospital care.

In the meantime, we affiliated with another shipbuilding corporation in the city which had secured a club house to be used as an emergency hospital. The army ambulance, manned by two of our men, was sent for those employees needing hospital care, and they were transported at once to the emergency hospital.

We found many pitiful cases in which everyone in the family was stricken with the disease, and in each case we took all of the members to the hospital. In one case we found the father, mother, and three children all sick and unable to walk. We wrapped them up in the bedclothes and took them in the ambulance directly to the hospital.

Our reasons for caring for our employees and their families were threefold. In the first place, our company is engaged in turning out ships for the government. It was distinctly to our advantage to get the men back to work as quickly as possible. By making it unnecessary for a man to stay home and take care of his sick wife and family, we added one more worker to our force.

In the second place, we have brought men to the Atlantic seaboard from all parts of the country—men who are unknown here, with no credit, no friends, no families to care for them when they are sick. We felt a large responsibility for their care after having brought them so far away from their established bases.

In the third place, we recognized that the situation was too large for the established hospitals to handle and that, in order to help the community cope with the unusual danger which confronted it, we had to do all that was possible to care for those who came directly under our supervision. In this way, we not only protected our own men but helped to prevent the disease from spreading in the community.

"Sickness in this country is still looked upon as a personal misfortune. The social conscience has not yet realized that sickness is an economic calamity for which all members of the community are responsible in varying degrees, and for which the whole community pays."—Alexander Lambert, M.D., chairman, Committee on Social Insurance, American Medical Association.

DEPARTMENT OF DIETETICS

Conducted by LULU GRAVES.

Please address items of news and inquiries regarding Department of Dietetics to the editor of this department, Home Economics Building, Cornell University, Ithaca, N. Y.

FOOD WASTE IN HOSPITALS*

Practical Suggestions for Eliminating Vast Waste in Institutions—Use of Basic Quantity Ration Tables and Waste Accounting System Superior to Garbage-Can Inspection in Promoting Economy

By CHARLES S. PITCHER, Steward and Deputy Treasurer, King's Park State Hospital, L. I.

The United States Food Administration has published a pamphlet entitled "Garbage Utilization with Particular Reference to Utilization by Feeding." The opening paragraph of this pamphlet is as follows:

"The American garbage pail, with its twenty-odd billion pounds of garbage per year, can well be considered one of our expensive luxuries, and if, through high prices, by the efforts of the Food Administration or otherwise, our per capita waste can be reduced by even a small per cent, no small additional supply of foodstuffs will be available. "Undoubtedly a large amount of garbage must exist even when the strictest economy is exercised. The garbage pail can not be entirely eliminated, but it can be enlisted in the cause of food saving. 'Put less in the garbage pail and take more out.' If all the garbage now being destroyed in cities of from 10,000 to 100,000 population were disposed of by feeding, approximately 30,000,000 pounds of pork, valued at about \$5,000,000 would be available, assuming only 50 percent efficiency. If we add to this the value of grease and tankage destroyed in cities of over 100,000 population, we have over \$11,000,000 per annum of potential food values being destroyed."

This pamphlet defines the meaning of the term garbage as follows:

"The term 'garbage' is a general expression for a purely local product. It does not designate any definite material or combination of materials. Its composition and even its general meaning vary in different localities. As used herein, the term 'garbage' will mean all refuse accumulations of animal or vegetable matter which has been intended for use as food for man. It will not include any material in the nature of ashes, rubbish or refuse, night soil, dead animals, street sweepings, manure, or similar materials."

On the fourth page of this pamphlet, under the heading "Amount of Garbage Produced," you will find the statement:

"Undoubtedly a big factor in the problem of garbage disposal is the fact that such comparatively small quantities accumulate each day in every household and that its nature requires removal at frequent intervals. From one-half to three-fourths of a pound daily, or approximately 200 pounds per annum, is the per capita production in the United States. Obviously the frequent removal of from 1 to 10 pounds of garbage from each residence is a decidedly more expensive operation than would be the collection of the same annual aggregate in cartload lots."

My discussion of food waste in hospitals will be con-

finied to refuse accumulation of animal or vegetable matter which has been intended for use as food for man. This refuse will be considered as waste, not garbage, until after it has been weighed and recorded and placed in garbage cans, after which it will be called "garbage." It is desirable to make this differentiation so as to distinguish the unweighed refuse from garbage.

In considering food waste in institutions, I will in a general way divide food waste into three subdivisions: (1) waste in purchasing and receiving food; (2) waste in preparing and cooking food; (3) waste in serving food in dining rooms.

All unnecessary waste of food supplies should be eliminated, for every pound of food supplies saved is more than equal to a pound of food supplies purchased, on account of the saving in cost of production, selling and transportation. The motto of every hospital or institution should be: "Raise and save everything possible." The utilization of farm and garden products is as important as their production, for there is no use of producing food supplies and then wasting them.

Each institution should have sufficient equipment so that the farm and garden products produced at the institution, or purchased, which are not necessary for use in the dietary from day to day, may be stored, dehydrated, or canned for future use.

An institution should be equipped with dehydrating and canning apparatus so that fruits and vegetables when in season may be dehydrated or canned in quantities. There will be great loss in the use of farm and garden crops, whether they are purchased or produced at the institution, unless they are properly utilized day by day. This loss will be greatest in institutions where there are farms and gardens, and it should be emphasized that neither farm and garden crops nor any other food supplies should be forced into the dietary of an institution, but only such quantities should be used as are necessary for the dietary from day to day, all the remainder being stored, dehydrated, canned or pickled for future use.

Supplies, so far as possible, should be purchased in season. The specifications on which they are purchased should be so drawn that the article is carefully and accurately described and should provide that, if the contractor fails to make proper deliveries, the institution may make purchase in the open market and recover the difference in cost from the contractor.

In the purchase of fruits and vegetables it is usually not practicable to make contracts, as these supplies can be purchased on competitive bids when needed, with the exception of such vegetables as can be purchased in quantities for storage.

All supplies when received should be weighed, counted, or measured, for in this way a very material saving can be made if dealers are given to short weight. The person inspecting the supplies should have sufficient training and knowledge to know what he is receiving, and the specifications should be so complete that he will have clear grounds for rejection or acceptance.

To prevent food waste in receiving, there should be adequate storage facilities so that all food supplies may be carefully cared for when they are delivered.

Refrigerating rooms cooled by mechanical means are superior to those cooled by ice, as the supplies may be kept much longer and in better state of preservation.

There should be sufficient storage space in which to store all perishable food as soon as received. Storerooms should be of sufficient size to insure proper separation and classification of supplies, and proper stock slips and rec-

* Read before the Twentieth Annual Convention of the American Hospital Association, Atlantic City, N. J., Sept. 24-28, 1918.

ords should be kept of the stock on hand, so there will not be unnecessary duplications in purchasing.

In places where cereals are liable to become infested by worms or bugs, if purchased in quantities, it is advisable to have the storage place scrubbed frequently, disinfected and whitewashed, and, in the summer months, if possible, to store such cereals as are on hand in refrigerated rooms.

Food supplies should not be issued indiscriminately to kitchens and dining rooms; they should only be issued upon requisitions. All issues should be made by weight, count or measure. It is not generally understood what large savings can be made through careful issuing of food supplies on requisitions.

The deliveries should be made from the storehouse to the kitchens in such a way that the supplies will not become contaminated or deteriorate while in transit. Each place of delivery, for its own protection as well as for that of the storehouse, should be provided with scales for weighing the supplies when received. Suitable storage should be provided in the kitchens for a day's supply of food and for keeping small quantities of canned and other goods which the cook needs for emergency use. Ice storage can be used in the kitchens, but it is much more satisfactory to use small mechanical refrigerating plants.

Molasses, syrup, vinegar, cereals—in fact, no food supply—should be issued in original barrels or packages unless the quantity used by a kitchen for one meal will require an original package. There is a great loss in issuing food supplies in bulk, since, when they are so issued, there is no check on the cook. Food may be conserved by issuing all food supplies in small quantities as needed.

Basic quantity tables of food supplies for issuing to given numbers of persons should be used. It has been found that, in hospitals where per capita tables for the issuing of food supplies are not used, frequently the same quantities of food will be issued for 100 persons as would be issued if there were 125 persons. I remember one instance in which as much food supplies were issued for 1,200 persons as had formerly been issued for 1,400. It can readily be seen that there should be a uniform system to govern the quantity of supplies issued per capita through the establishment of tables. Basic quantity ration tables for food supplies have been in use for over eight years with very satisfactory results. Hospitals can readily prepare their own basic quantity ration tables, as it is a simple operation.

To prepare these tables, the quantity of food supplies issued from the storeroom to the kitchens and dining rooms should be tabulated and each quantity divided by the total number of persons for whom the supplies were issued and the total number of meals for which the supplies were served. The final quotient will represent the per capita issue of food for each meal. For institutions where there are several kitchens, this plan should be followed out in computing the food supplies issued to each of the kitchens. When this has been done for each kitchen, the per capita quantities issued should be set up in vertical columns, so that comparisons may be made and the general average issue may be found by adding the given quantities of each of the food supplies issued to the several kitchens, and then dividing by the number of kitchens.

Where there are noticeable differences between the quantity issued to a particular kitchen and the average per capita issue to all kitchens, these differences should be investigated to ascertain the cause. The next step after making the computation is to prepare a basic quantity ration table for use in the institution. Institutions caring for different classes of patients will need different

tables, and it may be necessary to prepare several of these tables before the right quantity is arrived at. They may be prepared as described above by setting up the quantities in the same manner for the different classes of patients, officers, and employees. In arriving at the proper per capita quantities in preparing a table, due regard should be given to the quantity of waste left over after a meal. The waste accounting system, which I will mention later, will be found of great assistance in ascertaining whether the quantities arrived at in the table are sufficient or insufficient. Careful comparisons should be made of the waste and usable food returned from the dining rooms to the kitchens, for in this way it can be determined how nearly the tables meet the situation.

The basic quantity ration tables are for the purpose of insuring a proper and uniform quantity of uncooked food to the kitchens for the number of persons to be fed. The dietaries of a hospital should be made out a week, or at least a day, in advance and a copy supplied to the persons in charge of the dietary arrangements of the institution. From these dietaries the cooks in charge of the kitchens should prepare their requisitions on the storehouse, which should be checked by the dietitian, and the party in charge of the storehouse should see that the supplies are in stock, using the quantities as shown in the basic quantity ration tables previously established.

It is advisable for institutions to compute the food value of the food issued at least monthly to ascertain whether they are overfeeding or underfeeding. Too little care has been given to this important part of the dietary arrangements of an institution. No institution can tell whether or not it is wasting food or underfeeding its patients unless it makes computations of the food value of the supplies used.

The preparation and cooking of foods are so intimately related that it would be difficult to separate the two operations.

In the preparation of food it is advisable to utilize power-driven machinery where there is sufficient work to warrant it, that is, dough-mixers, dividers, moulders, meat-choppers, dish-washers, knife-cleaners, kitchen machines, etc. If vegetables are peeled, a vegetable-peeling machine should be used. Bread-cutting machines should be used for cutting the bread, a meat-slicing machine for slicing the meat, and butter-cutting machine for cutting the butter into individual portions. This will result in a saving of food.

Proper bakery equipment will increase the production of bread. Meat-choppers will allow the utilization of pieces of meat which would not otherwise be usable. Vegetable peeling machines will reduce the waste in vegetables from 15 to 20 percent, and, where vegetables have been very poorly peeled, even to the extent of 30 percent. Bread-cutting machines will save from 1 to 2 ounces of the bread issue per person per day. Meat-slicing machines will save from 3 to 10 percent in the slicing of meat over the best hand-carving. Butter-cutting or serving machines will frequently show a saving of one-third, particularly in cases in which the butter has previously been placed on the table and the persons in the dining room allowed to take butter at will, with the result that it has been left on the plates and not used.

The preparation of meat naturally begins in the butcher shop. The meat should be requisitioned according to the basic quantity ration tables. Beef, mutton, and pork for roasting, and beef and mutton for boiling should all be weighed in the butcher shop in the usual way. After the meat is weighed, each separate lot for each kitchen should be boned and, where necessary, rolled and tied to keep it

together. It is desirable to bone all meat with the exception of steak, chops, and stew, and the use of steak and chops should be limited. By "boning" is meant the removal of all bones from pieces of meat which are used for roast meat or boiled meat, so that they may be carved with a meat-slicing machine. The meat should be cut into as large pieces as can be roasted in the oven or in a steam roaster, for large pieces of meat can be carved to better advantage in a meat-slicing machine than small ones.

For roasting meat and for baking, oven thermometers should be used. Regular oven thermometers are now manufactured for this purpose, and the manufacturers of these thermometers publish booklets giving the temperature at which certain meats should be roasted and also the temperature for different kinds of baking.

It is advisable to roast meat as rare as it will be eaten, since this process alone effects a large saving of meat. As fast as small pieces of meat are roasted they should be removed from the roaster or from the oven. Rare, medium, and well-done pieces can be obtained in this way.

Excess fat which is not needed in cooking the meat should be trimmed from the meat in the butcher shop before it is issued to the kitchens. It is a good practice to save fat under normal conditions, but, now that fat is so urgently needed for the carrying on of the war, great care should be exercised to see that this is done, for, by this procedure, a large amount of fat can be secured for cooking purposes which will make it possible for institutions to reduce their purchase of fats.

The use of oven thermometers will effect a saving in meat of from 3 percent to 10 percent, and even as high as 20 percent in some cases, by causing the cook to maintain the proper temperatures in the ovens.

Where there is excess fat left on the meat it is decomposed by the heat in roasting or it may be lost when the meat is boiled unless it is carefully skimmed from the kettle. All drippings or other fat produced in cooking should be carefully saved. In each kitchen there should be a kettle set apart for the saving of fats so that, after they have been used to such an extent that they have become too darkened for further use in foods, they may be used in soap making.

It is not only a waste, but also a detriment to the meat to carry too high oven temperatures. The fat is not only decomposed but the protein of the meat is so hardened that it becomes almost indigestible. Aversions on the part of persons to rare meat can be overcome by gradually cooking the meat more rare each week and in this way accustoming them to eating rare meat. By the proper cooking of meat and carving it with meat-slicers as high a saving as 30 percent may be made over poor cooking and hand carving. A meat-slicer will show a material saving over the most skillful hand carving.

To prevent the cooks from overcooking the meat, it may be weighed just before it is placed in the oven and again after it is roasted. Roast beef and mutton should not lose in cooking more than 20 percent in weight, and roast pork 25 to 30 percent. Chops and steaks may be weighed before broiling or frying, and after the cooking process. Other meats may also be weighed to advantage before and after cooking. It may not be practicable to do this at each meal unless sufficient help is available, but tests should be made from time to time, to guard against undue loss in the cooking of the meat. The weighing of meat before and after cooking will save a surprising quantity.

To prevent the waste of vegetables it is well to have one central peeling room, which should be supplied with

modern equipment for the washing, weighing, and peeling of vegetables and the preparation of vegetables for canning or dehydrating. Very material savings of vegetables can be made through centralizing their preparation.

No bread should be delivered on oral orders to kitchens or dining rooms; requisitions should be prepared on a basic quantity ration table for the bread to which the dining room is entitled, and there should be no deviation from the table of quantities without special reason. This will prevent the baking of an oversupply of bread, which may become stale. The dining room will take better care of the bread and will give more careful supervision to the serving of it if this rule is adopted. The elimination of the waste of bread in kitchens and dining rooms will result in a large saving in flour.

In serving bread it is recommended that one slice be served at a time. When the inmates of an institution enter the dining room it might be well to have a slice of bread beside each plate, for nearly every one will eat a slice of bread. A certain number of inmates will eat two slices, a few will eat three, and a smaller number will eat four slices; but if, as is the practice in some dining rooms, three slices are placed beside the inmate's plate at the beginning of the meal, there can be but one result—a large wastage of bread. When large loaves of bread are baked, the slices should be cut in two, so that too large slices will not be served at a time.

The remarks I have just made about bread refer particularly to institutions where there is more or less custodial care. In general hospitals having tray service, the bread used can be more easily controlled, as there can be a standard quantity established for serving on each tray. In tray and dining room service, care should be taken to see that uniform quantities are served, for this will prevent waste of food. Where a person requires more, he can be given a second serving.

It is now quite a general practice, as a means of preventing waste and securing satisfactory dining room service, to adopt standard-size dishes for use in serving the food. Dishes which will hold a certain number of servings should be used, together with individual dishes that will hold a portion. If too small dishes are used, the services will be insufficient, and, if too large dishes are used for a portion, too large quantities will be served, resulting in a wastage of food, especially where graduated ration dippers are not used. Institutions sometimes use bowls and cups from two to three times larger than necessary.

In serving in bulk from the kitchen, dippers which are graduated to show a definite number of portions of food can be successfully used, and, where dishes have not been standardized so that a uniform portion of food will be given, ladles or other means of service can be used to divide the food into individual servings.

WASTE ACCOUNTING SYSTEM

Dining room waste is considered a hard thing to get at—presumably, because it is not usually classified.

Persons who have inspected garbage cans know that meat, potatoes, puddings, bread and other foods that appear to have been good when they were thrown in the cans are found mixed with the garbage, and one frequently hears the statement that institution kitchens and dining room employees are so wasteful that a number of families could be fed from the good food thrown into the garbage. Inspection of garbage cans will not prevent lazy or indifferent employees from throwing good food left over from meals into the cans, for they know that no adequate mental image can be formed of the good food in a can of garbage, even though the garbage is dumped

from the can on to a platform or the ground and examined. It is impossible to visualize accurately quantities and kinds of good food after it has been thrown into the garbage, and this fact is known to administrative officers.

Even with the assumption that the employees are efficient and that each is conscientiously doing his work, the inspection of garbage cans is still a failure, for the employees have no definite means of determining how much garbage there should be. From week to week, without attracting attention, the garbage may gradually increase in bulk. The most alert employee will not notice this increase, for the quantities will fluctuate from day to day so that the gradual increase is not noticed.

The failure of garbage-can inspection to give satisfactory results is due to the fact that its success depends solely on the opinion formed by the person making the inspection, who only "guesses" that the garbage is not excessive; and, as time passes, this inadequate inspection becomes lax, for there is no way of checking results through making comparisons of different kitchens.

A waste accounting system will overcome these difficulties. The good food that has not been served is classified as "usable food," which can be utilized by kitchens.

The waste and the good food are returned to the kitchen in separate containers to be weighed and recorded on the forms provided for that purpose.

This method of handling waste and usable food is a satisfactory way of preventing good food from being thrown in the garbage, for, through its operation, everything is separated and weighed, so far as it can be, before being thrown into the garbage, and this gives a complete record of the garbage, from which comparisons can be made of the waste (garbage) of the different kitchens.

The weighing of the waste not usable is one of the means of determining whether the patients are receiving sufficient food, and the weighing of the "usable food," which can be utilized by the kitchens (good food), is an additional means of determining whether the patients are receiving sufficient food. The weighing of both the good food and waste not usable (garbage) shows whether or not sufficient food has been issued, and, in the event of an official inquiry with regard to the feeding, the waste records would show whether or not enough food had been served.

Some of the advantages readily recognized by administrative officers of institutions to be obtained by the use of a waste accounting system over garbage-can inspection, are easily discernible.

With a waste accounting system all the waste (garbage) is separated and classified under various heads. The separation and weighing of the waste gives an administrative officer very necessary information as to the quantity left after a meal and shows conclusively, when comparisons are made between a number of dining rooms, whether or not a dining room is having a normal waste of food. It is a decided advantage to an administrative officer to have accurate information as to what makes up the waste left over from a meal. Too much waste of any particular article of food will indicate to him and the dietitian that too much food has been served, that the food was badly prepared or that, for some reason, it was unacceptable, and this will at once start an inquiry to determine the cause.

On first thought, it might seem that this information would be difficult to obtain and that a large amount of additional work would be required in kitchens and dining rooms. This, however, has not proved true, for the experience in the use of a waste accounting system in the New York State hospitals and other institutions has

shown that this information may be obtained without increasing the number of employees. In using the waste accounting system all the waste is separated and classified under the various heads. The food left on the plates which cannot be separated into the different kinds is recorded as "plate scraps"; the bread left on the tables which has been served is recorded as "bread"; potatoes, as "potatoes" (where boiled potatoes are served, the skins are classed as "potato skins"); meat, as "meat"; vegetables, as "vegetables"; fish-bones, etc., according to name. It is necessary to classify all food served and left on plates as "waste"; food remaining in the serving room or on the table, unserved, should not be classified with the "waste" but should be returned to the kitchens as "usable food."

The waste accounting system has been used with very marked results in one of the New York state hospitals since 1911, and in all of the New York state hospitals since 1917; in some institutions in the state of Pennsylvania for over five years; and in all institutions of the Province of Ontario, Canada, since November, 1914. Such marked results have been obtained through its use that institutions have reported they had either to decrease the number of hogs formerly kept, as there was not sufficient garbage to feed them, or to purchase feed for the hogs. The feeding of garbage to swine is a ready way of utilizing garbage, but garbage is actually an expensive hog feed. From the standpoint of economy and food conservation, all unnecessary garbage should be eliminated. No garbage, therefore, should be allowed to result from a meal with the idea that it is not a dead loss on account of being fed to the hogs, since hog feed can be purchased at a much less cost than the food supplies contained in garbage.

It is reasonable to expect the following results from the use of a waste accounting system:

1. It checks both underissues and overissues of food to dining rooms.
2. It causes dining rooms to serve food more carefully.
3. It prevents dining rooms from throwing a large quantity of good food into the garbage cans.
4. It teaches the kitchen and dining room employees to handle food supplies in a careful and economical manner.
5. It gives kitchen and dining room employees an incentive to do good work, as the waste reports show which kitchens and dining rooms are run efficiently and which are run poorly.
6. It is beneficial to the inmates of an institution because it results in a minimum of waste of food in the kitchen and dining room operations and more care in cooking and serving, and because, as the waste is lessened, more food is available for service.
7. If the saving resulting from the use of the waste accounting system is not needed to improve the dietary of the patients, there will be a reduced expenditure for food supplies.

HOW TO USE A WASTE ACCOUNTING SYSTEM

In places where a waste accounting system has not been used, it would be best to institute its use by first weighing all waste not usable and making one entry of it under "plate scraps" on report blanks. Every few days, as the kitchen and dining room employees grow more accustomed to the new order of things, subdivisions of the waste can be made, until the system is in full operation.

Great care should be given to the "usable food" which can be utilized by the kitchens, which should also be entered on the report blanks.

When using the waste accounting system the dining rooms, instead of dumping all the waste from the tables into one container after the meal, gather up separately, as far as possible, the different food articles which have been served and are left on the plates and on the tables.

Where there is more than one ward served in the same dining room, the different wards gather the waste from their tables and bring it to the serving room of the dining room, and the same kind of waste from the tables of the different wards is put in one container, after which the several containers are sent to the kitchen to be weighed. The food on the tables which has not been served is classified as "usable food" and returned from the serving room to the kitchen in separate containers, to be weighed and utilized again in subsequent meals. An employee in each kitchen is detailed to weigh the waste and usable food when the dining rooms bring it back to the kitchen. When a kitchen is cooking for but two or three dining rooms, the additional work is of little account, but, where they receive waste from several dining rooms, the installation of the system causes some additional work at the start. After the system is in operation, little trouble is experienced, and the cooks prefer this method to the old way for the reason that, with the old system, they could not know when too much of any food was supplied to a dining room. Under garbage-can inspection the different kinds of food left from a meal are returned to the kitchen in one receptacle, into which all kinds of food has been thrown, and, if a dining room receives too much or too little of any kind of food, it is hard for the cook to determine this fact. With the waste accounting system, an overissue of any food sent to the dining room is plainly indicated when the waste and usable food is later returned from the dining room to the kitchen and weighed.

In separating the food and sending the proper quantities to the different dining rooms, the cook has to use considerable judgment and, unless he has some way of checking the subdivision he has made of the cooked food in bulk, he is very liable to make mistakes and send too large or too small quantities to some place. The assistance the waste accounting system gives the chef and the cooks in the accurate distribution of cooked food to the different dining rooms more than offsets the work the system causes.

RECORD OF WASTE

Accurate records should be kept of the waste and usable food returned to the kitchens from the dining rooms. For this purpose a waste report blank should be used in the kitchens, on which is recorded what is returned by the dining rooms. A supply of these blanks should be placed in a suitable binder and kept in the kitchens, proper entries being made after each meal on the blank for that day.

Some institutions make daily summaries of these blanks, other institutions weekly summaries, and still others prefer to make a monthly summary. The weighing and recording of the waste and usable food is usually done by the kitchens, but in some institutions the dining rooms are required to do this. It is recommended that the weighing and recording of the waste be done in the kitchen, so that this work may be centralized and the kitchens used in keeping a check on the dining rooms. It is also recommended that the other records, monthly summary, and comparison sheets, be prepared in one of the administrative offices from the information supplied by the daily reports of waste and usable food returned by dining rooms to kitchens.

A properly supervised dietary and the operation of a waste accounting system will result in distinct economy through the prevention of food waste in hospitals. If a hospital has a census of 2,000 persons, it means that 6,000 meals are prepared each day. If but one ounce more than

necessary of waste per person a day is thrown into the garbage, it will aggregate 125 pounds of food thrown away per day; in one year the waste will be 45,625 pounds; if this waste is worth 10 cents a pound, as it may easily be worth, it will mean that, for every 2,000 persons, the institution is needlessly throwing away \$4,562.50 worth of food. The average institution is likely to save considerably over one ounce per capita per day by a well-operated waste system. After the waste system is in thorough working order, the table waste per capita for employees should not exceed 2½ ounces daily, and for inmates, not more than 1½ ounces. The returned usable food is usually from one-half to three-fourths as much as the waste. The quantities given are maximum quantities, and hospitals should have less waste than this.

The United States Food Administration is very much in earnest in its efforts to prevent food waste. The Statistical Division Information Service is receiving monthly reports of garbage collections and garbage grease from a number of cities. A compilation of the information received for the month of July, 1918, shows that the collection during July of garbage was 9 percent less than for the corresponding month last year. There is a slight increase in the collections for the month of July over that in June, 1918. The compilations for garbage during July, 1918, were received from 74 cities. The records of seven of these cannot be included because of insufficient data, leaving 67 cities, with a total population of over 20,000,000, to supply the data assembled. For these cities, the amount of garbage per capita for the month is about one-half pound daily. The summary of garbage grease recovered in July, 1918, shows a decrease of 16 percent from July, 1917. The returns are from cities having a total population of over 6,500,000. The percentage of garbage grease collected is less in July, 1918, than a year ago.

In order to impress upon his troops the lesson of individual food conservation, the commandant at Fort Meyer paraded his soldiers in a formal manner before the crowded garbage tins of the camp. "There is evidence," he told them, "that your eyes are bigger than your stomachs."

"Prominent among numerous economies lately introduced at army camps and cantonments are those dealing with kitchen by-products. Every organization of the army conducting a 'mess' makes the following classification of kitchen waste produced in preparing and serving each meal.

CLASSES OF WASTE PRODUCTS

A. *Bread*—which will include all breadstuff unfit for human food. It will be dried and sacked for delivery.

B. *Cooked meat*—which will include all meat gathered up from the individual plates after meals.

C. *Raw fats and meats*—which will include the trimmings and raw scraps rejected for use as food and meat condemned by health authorities as unfit for human consumption.

D. *Cooked grease*—which will include all grease discarded as being of no further value as human food.

E. *Bones*—which will include all bones discarded in the preparation and use of human food.

F. *Other garbage*—which will include all unusable portions of food not otherwise classified and will not include coffee grounds, glass, or other substances injurious for use as food for animals. This shall be mixed with ashes and disposed of in like manner.

"The first five classes of waste products are disposed of through commercial channels chiefly for conversion into grease, glue, fertilizer, poultry and animal feeds. What should particularly interest farmers having land near army camps and cantonments is the Class F material, the 'other garbage.'

"The United States Food Administration calls particular attention to the desirability of such garbage as feed for hogs. It is free from coffee grounds, glass and other injurious substances, and large camps will produce 8 to 10 tons of this feed a day, enough to feed 800 hogs. Last year the city of Worcester, Mass., fed its garbage to hogs and reported swine raised and sold to the amount of \$44,487; the profits exceeded \$36,000. If a city can get these results, a trained farmer who feeds his hogs high-grade

camp garbage should be able to do as well or better. Methods of practical garbage utilization by hog feeding will be supplied by the Food Administration on request."

The newspaper release of the United States Food Administration, from which I have been quoting with reference to classes of waste products in army camps and cantonments, was sent to farm journals only for release after August 19th.

The Federal Food Board for the state of New York, in its latest bulletin for September 9, 1918, says:

"Sixty nutrition officers have been appointed in the national army camps to carry on the work of curtailing waste of food in cantonments and camps. They will advise as to the nutritional values of dietaries and will co-operate with the officials to prevent spoilage of food. In one camp the average edible waste was found to be 1.12 pounds per man per day. Instructions for economizing were given, which resulted in reducing the waste to approximately 0.43 pounds per man per day, according to the findings in a second survey. It is expected that this plan will mean a considerable saving to the government in money as well as an aid to food conservation."

Institutions should certainly not have as much waste as army camps, since they have better facilities and better equipment than the camps have and their personnel does not change so frequently. It behooves all hospitals and institutions to redouble their efforts to prevent food waste, for, under normal conditions, over one-third of the total expenditures of an institution is for food supplies. It is not only a matter of economy to prevent food waste but also a patriotic duty. We have all been electrified by the five words "Food Will Win the War," and there is no better way of providing this food than by saving what we have through prevention of food waste. On account of their special training dietitians are better equipped to lead the movement to prevent food waste than other persons, and they are, I believe, doing their part to assist the United States Food Administration in its conservation program.

I would urge all persons to redouble their efforts to prevent waste of food for, despite this year's bountiful harvest, food conservation must be intensified to meet the demands of our army and the civilian populations of the United States and allied countries.

* * * *

NEWS NOTES OF DIETITIANS

Miss Evaline Kerr, formerly of Alameda County Hospital, California, is now with Base Hospital No. 1 at Fort Sam Houston, San Antonio, Texas.

Miss Bernice Butler, who has been at Camp Doniphan, Fort Sill, Oklahoma, is now with Hospital Unit 70. The latest news from Miss Butler was that she was in New York City getting equipment and making other preparation for overseas duty.

Miss Aline Brownlie has been appointed dietitian in Fabiola Hospital, Oakland, California.

Last month we reported the appointment of Miss Violet Ryley to supervise the dietitian work in the Army Nurse Corps and Red Cross. Miss Ryley resigned her position and returned to Canada about the time our copy went to press. She did not assume the duties of the work here, but is doing her work in Canada with the Invalid Soldier's Commission.

Miss Lenna Cooper of the Battle Creek Sanitarium, Battle Creek, Michigan, has been appointed to succeed Miss Ryley. Miss Cooper has had a wide experience in institutional work and is familiar with the situation in the dietary departments of both civil and military hospitals. Her keen perception and good judgment will help to overcome many of the difficulties and problems which have prevailed in the field of dietetics.

Miss Maude Anne Thomas, chief dietitian of the Philadelphia Hospital, Philadelphia, died of influenza, Oct. 21, 1918, at the hospital, after a two weeks' illness. Miss Thomas was dietitian at The Massillon Hospital, Massillon, Ohio, and at The Southside Hospital, Pittsburgh, for some years before coming to Philadelphia. She took up the duties of chief dietitian at the Philadelphia Hospital early in 1917. Her work at that place was of splendid character. In spite of war conditions she succeeded in instituting improvements and in solving many difficult problems. Her cheerful disposition and loyal cooperation were always inspiring, and she will be greatly missed by her associates and friends. Miss Thomas was a member of the dietitians' section of the Home Economics Association of Philadelphia.

The Care of Tuberculous Soldiers

Statistics gathered by the medical department of the Italian Army show that the number of soldiers discharged on account of tuberculosis is inversely proportionate to the time passed under arms; in other words, that the number of tuberculous soldiers who have served only one or two months is very large, while the disease is much rarer among the men who have served a long period of time. This is clearly due to the fact that a great number of men with latent tuberculosis was taken into the army. The medical department now insists on a close and rigid examination of all recruits, and men with suspected tuberculosis are sent to special centers where they are examined by the most modern methods and kept under observation for a certain period of time, says S. Pisani, writing in the *Rivista Critica di Clinica Medicina* of Florence.

The soldiers discharged from the army because of tuberculosis are divided into three groups, cases of incipient, intermediate and advanced tuberculosis. Patients of the first class are sent to climatic institutions in the mountains or on the seashore, seven of which under management of the Red Cross are already in operation. When cured these soldiers return to the army. The cases of the second group are returned by special Red Cross train to the provinces from which they came, where they are cared for and treated in open-air institutions. Patients of the third group, the hopeless cases, are cared for in special tuberculosis hospitals. The author calls attention to the great difference of the treatment of tuberculous soldiers now and before the war, when they were simply sent home and left to themselves.

The New Radiological Division of the St. John's Hospital in Turin

The new radiological clinic of St. John's Hospital is housed in a separate pavilion and is divided into two sections, the radiological institute proper and the hospital section. The first section has eight large rooms devoted to diagnosis, radium treatment, x-ray application, etc. The hospital section has 17 beds, 10 for female and 7 for male patients. The institution is splendidly equipped with all kinds of apparatus. It has 8 radium tubes containing, in all, 340 mg. of radium.

The clinic is described by C. Boidi-Trotti, in *Radiol. Med.* of Milan.

Many people are born crying and die disappointed. They chew the bitter pill which they would not even know was bitter if they had the sense to swallow it whole in a cup of patience and water.—C. H. Spurgeon.



LETTERS TO THE EDITOR

Splendid Industrial Cooperation Results in Speedy Influenza Relief

To the Editor of THE MODERN HOSPITAL:

Thinking that you would be interested in knowing the measures taken "back to the Yards" when the influenza epidemic was at its height, I am sending you the following brief description.

About Friday and Saturday, October 18 and 19, from the reports of all nurses and doctors, it looked as though we were in for the worst epidemic in the history of this district. There were many deaths, new cases increasing rapidly, and whole families stricken at the same time. In some cases, parents were ill and there was no one to provide food for the children. The scene as it was could never be painted in its true colors.

Dr. O'Neil of the Municipal Tuberculosis Sanitarium was appointed by the health department as officer in charge of this district in influenza emergency measures. As there was no longer any room in local hospitals, he conceived the idea of an emergency hospital at the University of Chicago Settlement, 4630 Gross avenue.

The idea soon became a reality. The packing companies, acting through the Stock Yards Community Clearing House, immediately responded to the need, so that beds, cots, blankets, etc., were quickly transferred from summer camps to be used for emergency hospital purposes. Other equipment that could not be immediately furnished by the packing companies, settlement, or other organizations was purchased outright. It was a desperate move to save lives. Within a short time the arrangement was completed and a real hospital was in operation in the settlement gymnasium with four nurses in charge and twenty patients. As this effort was made when the epidemic was at high tide, we did not have to provide for more than twenty patients, for regular hospitals soon reported room for community cases.

The unique feature of this endeavor was the quick action which brought relief on short notice, the splendid cooperation of industries, local doctors and nurses, and local social organizations. Of the twenty patients received but one died, and this was a small child who was almost beyond hope when brought to the emergency hospital. There were several very serious cases of pneumonia, but with splendid care the patients fully recovered and were soon discharged. It was the feeling of those who shared the responsibility of the hospital that without a doubt, lives were saved by this heroic effort.

Diet kitchens were also established at the University Settlement, House of Social Service, and Chase House, and more than five thousand meals were carried by volunteers to families who were not physically able to provide themselves with food. It was not necessarily a matter of charity but rather a matter of providing proper food in the quickest way possible for those who were not able to prepare it for themselves.

The packing companies paid the entire expense of these diet kitchens, as well as the expense of the hospital. They purchased the food and delivered it to the kitchens, in order to save the time and energy of those who were preparing and distributing it.

I have taken the pains to go into some detail on this subject, as I am sure THE MODERN HOSPITAL is especially interested. Perhaps this is one of the most unique experiments in the city in dealing with a very bad situation, which luckily soon passed.

The output of our diet kitchen is now reduced to forty or fifty meals a day, and the hospital is no longer needed. The number of deaths and new cases, as now reported, is very low.

EMERSON O. BRADSHAW,

Director, Stock Yards Community Clearing House, Chicago.

The Hospital of Ilbarritz, a Center for Patients with External Tuberculosis

Much has been written about pulmonary tuberculosis in the armies of the present war, but few writers mention the cases of external tuberculosis. Yet this class of patients, especially cases of tubercular lesions of the bones and joints, is very large. As far back as 1916 the French medical service established special centers for this form of tuberculosis along the west coast of France, at La Rochelle, Arcachon, Cap-Breton and Biarritz. The hospital of Ilbarritz, near Biarritz on the Bay of Biscay, was established in the beautiful chateau of the same name, situated on a high promontory overlooking the bay. The rooms are large, airy, and provided with ample verandas. This hospital is peculiarly well adapted to the treatment of external tuberculosis. The usual therapeutic methods are combined with heliotherapy. Immobilization is one of the chief elements of the treatment. The patients are kept in their rooms only during the night. Early in the morning they are rolled out on the large verandas and terraces where they are exposed to the curative effects of the sunlight and breathe the invigorating salt air of the bay. The hospital is under the management of Madame Williams assisted by two American ladies, Mesdames Frothingham and White. It is described by Peyret and Fournier in the *Journal de Médecine de Bordeaux*.

Tuberculosis Sanatoriums in High Altitudes and on the Plains

E. R. Coni maintains that there is no special climate for the cure of tuberculosis. For successful treatment the disease requires merely fresh air, rest and good and abundant food. It is not necessary to send the patient to the mountains, where he is away from his family and becomes a victim of nostalgia and where he lacks the conveniences and aids which his delicate condition requires. Sanatoriums should be established in the country, not far from the great centers of population. The great mountain sanatorium, Santa Maria, with 700 beds, has not been a success, while the Tornu Sanatorium, established in 1904 and situated in the plain, about ten miles from Buenos Aires, has been remarkably successful in its cures. To combat tuberculosis the author proposes that the government should establish numerous tuberculosis dispensaries and two large sanatoriums near the capital, one for men and one for women, besides an agricultural colony where the patient could complete his cure before returning to his former work.

Coni's article appears in the *Semana Medica* of Buenos Aires.



Dispensaries, Their Management and Development. By Michael M. Davis, Jr., Director of the Boston Dispensary, and Andrew R. Warner, M.D., Superintendent of Lakeside Hospital, Cleveland, Ohio. Cloth, pp. 426, \$2.25. The Macmillan Company, New York, 1918.

That a book like this has not appeared sooner is rather amazing when one considers what an increasingly important part dispensaries have been playing in the care of the ambulatory sick during the past fifteen years, a period during which their number has increased from about one hundred and seventy dispensaries to approximately three thousand of all classes. Stimulated by the unrelenting efforts of agencies organized to combat disease and by the growing interest in health as a national asset, we may expect dispensaries to continue to grow in number, and so evolve in character as to fill a much larger field of usefulness not only in the treatment of sickness but in the prevention of disease.

In the words of the joint authors, the book has a three-fold object: (1) to depict briefly the history and present extent of dispensaries in the United States; (2) to present the practical details which all people, including superintendents, physicians, nurses and social workers, who are working in dispensaries, particularly need to know; (3) to present the dispensary as a form of organization not only for rendering efficient medical service to the people, but also for benefiting the medical profession by stabilizing the economic position of the average physician.

The history of dispensaries in the United States is indeed depicted briefly, and if the reader comes to the book looking for more than the barest outline of the growth of dispensaries in the United States, he is doomed to disappointment. But this is a virtue rather than a fault, since the inclusion of a more elaborate historical exposition would have made the book uninvitingly long. The sections of most practical use are those devoted to fundamental principles and technic. Here the reader who is interested either in organizing a new dispensary or in organizing additional clinics in already existing institutions, or in improving the organization, equipment or technic of existing dispensaries, will find a wealth of practical suggestions and information, whose peculiar value lies in the fact that it emanates from the eight years of experience of one of the authors in reorganizing and building up one of the largest dispensaries in the country.

The last five chapters of the book bulks large in proportion of a worth-while character, and are especially stimulating. With the passing of the "family physician," and the increase in specialization, we are on the verge of a new era—the era of cooperative medical practice in which the dispensary is bound to play one of the leading roles. How this development will tend to stabilize the economic status of the average physician is interestingly set forth. The authors are not unmindful of the deficiencies of present dispensary organization, and realize that these defi-

ciencies must be corrected if dispensaries are to occupy acceptably the larger sphere they seem destined to fill. The rapidity with which dispensaries will develop into agencies of larger service to the people will depend very much upon the rapidity with which the general public comes to know what the cooperative practice of medicine means, and what it involves.

Appended to the volume is a comprehensive bibliography, suggestions for by-law and administrative rules of a dispensary, and a copy of the recently enacted Massachusetts dispensary law.

BOOKS RECEIVED FOR REVIEW

Walter James Dodd. By John Macy, Writer and Critic. A biographical sketch with illustrations. Cloth, pp. 64. \$1.50. Board. Houghton, Mifflin Co., Boston, 1918.

Hygiene of the Eye. By Wm. Campbell Posey, A.B., M.D., Professor of Diseases of the Eye in the Philadelphia Polyclinic; Ophthalmologist to the Department of Physical Education of the University of Pennsylvania; and Chairman of the Commission on Conservation of Vision of Pennsylvania. Cloth, pp. 331, 120 illustrations, \$4.00. J. B. Lippincott Company, Philadelphia, 1918.

English, French, Italian Medical Vocabulary. By Joseph Marie. Including reference tables of special value to physicians and nurses, phrases for directing first aid to the injured, articles on pronunciation, European money tables, etc. Cloth, pp. 112, \$0.50. P. Blakiston's Son & Co., Philadelphia, 1918.

In the Soldier's Service—The War Experiences of an American Woman in England, Belgium and France, 1914-1918, with illustrations. By Mary Dexter. Paper, pp. 209, \$1.50. Houghton Mifflin Company, Boston, 1918.

Anatomy and Physiology for Nurses. By Diana Clifford Kimber, formerly Assistant Superintendent New York City Training School for Nurses, formerly Assistant Superintendent Illinois Training School, and Carolyn E. Gray, Principal City Hospital School of Nursing, New York. Cloth, pp. 490, 225 illustrations, \$2.60. The Macmillan Company, New York, 1918.

Animal Parasites and Human Disease. By Asa C. Chandler, M.S., Ph.D., Instructor in Zoology, Oregon Agricultural College, Corvallis, Oregon. Cloth, pp. 570, illustrated, \$4.50. John Wiley & Sons, Inc., New York, 1918.

Principles of Surgical Nursing. A Guide to Modern Surgical Technic. By Frederick C. Warnshuis, M.D., F.A.C.S., Visiting Surgeon, Butterworth Hospital, Grand Rapids, Mich., Chief Surgeon, Pere Marquette Railway. Cloth, pp. 277, with 255 illustrations, \$2.50. W. B. Saunders Company, Philadelphia, 1918.

How France, During the War, Has Organized the Anti-tuberculosis Work with Regard to Infected Soldiers

All soldiers infected, or suspected of being infected with tuberculosis, are divided into three groups, curable cases, permanently incurable cases and an intermediate class. The curable patients are treated in special hospitals, *stations sanitaires*, and, after being cured, take their former place in the army or are employed in an auxiliary service. The incurable cases are either isolated in special hospitals or sent to their homes if there is no danger of spreading the infection. The patients of the third group who can still perform useful work, are sent to their homes after having received prophylactic instructions regarding their disease. The *stations sanitaires*, of which there are at present twenty-eight, with 5,500 beds, have the character of sanitariums. The educational work is in the hands of competent ladies, usually widows of officers. The patients sent to their homes are under the constant supervision of visiting nurses.

E. Bertarelli describes this work in the *Rivista di igiene e di san. pub. di Parma*.

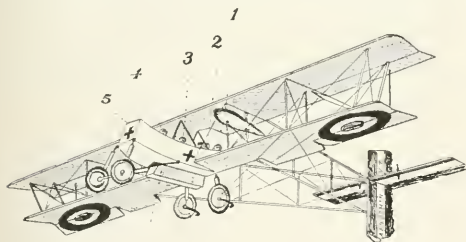
CURRENT HOSPITAL LITERATURE

ALBERT ALLEMANN, M. D., Foreign Literature.
Army Medical Museum and Library, Office of the Surgeon-General,
United States Army.

The Radio-Chirurgical Aeroplane. M. A. Nemirovsky and M. Tilmant. *Bull. Acad. de Méd.*, 1918, LXXX, No. 35.

M. Nemirovsky, head of the radiological laboratories of the Spanish and Russian hospitals, and M. Tilmant, a member of the French Army Medical Corps attached to the United States Army, describe an aeroplane intended to carry aid to the wounded. The machine carries a pilot, a surgeon, and an radiologist (who should also be qualified as a surgical assistant), surgical material, dressings, and an x-ray installation. It is evident that the object of this formation is not to carry the wounded and to operate on them in an aeroplane, but rather to carry fairly complete surgical and radiological equipment and the necessary personnel either to an individual wounded man or to points where there is urgent need of reinforcement of the surgical staff.

The apparatus has the advantage of extreme speed and of not encumbering the radios or of being blocked by the



The Nemirovsky-Tilmant radio-chirurgical aeroplane; (1) surgical-assistant-radiologist; (2) electric generator; (3) pilot; (4) surgeon; (5) surgical instruments; (6) sterilized dressings; (7) x-ray apparatus.

congestion of traffic. The instrumental equipment has been especially designed with a view to lightness and compactness, and, as shown in the illustrations, it is highly compendious.

The electro-generator of the aeroplane itself furnishes the current for lighting and for the x-rays. It needs to be supplemented by a small transformer and interrupter. The same current can be used for heating the electric sterilizers.

Antituberculosis Organization in the Provinces. E. R. Coni. *Semana Med.*, Buenos Aires, 1918, XXV, No. 17.

The example of Buenos Aires, where an energetic anti-tuberculosis campaign has been organized, was imitated

only by the city of Rosario, where an association for combating tuberculosis was put on foot. In the other provinces, nothing or very little has been done. The principal means of combating tuberculosis is the dispensary, which forms a center of action, investigation, and prophylaxis. Such dispensaries should be established in all the capitals and chief cities of the provinces, and should be controlled by the provincial and municipal medical officers. At the same time tuberculosis hospitals should be established, and the general hospitals should be entirely freed from tuberculous patients. Later, the provinces should also be able to establish sanatoriums for the cure of tuberculosis, either in the mountains or on the seacoast. The author mentions sanatorium statistics of the Prudential Insurance Company of America. From 1909 to 1913, 6,767 patients received sanatorium treatment, and of these 43 percent were cured, while 30 percent were greatly improved.

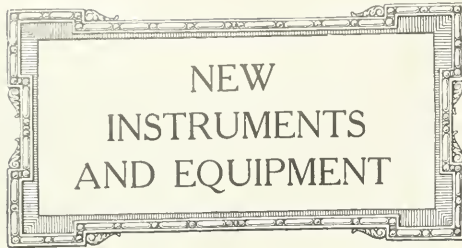
The Neurological Center of the Territorial Army at Genoa. *Quaderni di psichiatri.*, Genoa, 1918, V, No. 7.

This military neurological center consists of two distinct hospitals, the Missionari and the Spinola Hospital. The former is devoted to simple functional psychoneurotic troubles. It has an isolation ward for excited cases and for patients needing close observation, and a ward for quiet psychoneurotics, a division for patients with organic lesions not due to military service (myelitis, lues), and an officers' division. The rooms are small, holding only two or three beds in order to facilitate eventual isolation and to obviate contagion in the hysterical forms as much as possible. The functional hysterical cases (aphonia, stuttering, abasia, paralysis, etc.) are subjected to a new and special treatment. After a short period of isolation, during which suggestion is used, the patient is brought into a state of excitement, and a strong electric current is applied, while at the same time suggestion and oral persuasion act on the mind of the subject. This method has been successful in the most inveterate cases.

The Spinola Hospital receives only patients with traumatic lesions of the nervous system. The therapeutic principles of the hospital are as follows: All psychogenic (hysterical) complications resulting from the organic lesion must at once be removed, such as tremors, contractures, false positions of the members, etc. Each patient must be studied closely and intensely. No patient is allowed to remain inactive.

The Psychopathic Hospital of the Laboratory of Social Hygiene, Bedford Hills, N. Y. Katharine Davis, E. E. Southard et al. *Jour. Sociol. Med.*, Pittsburgh, Pa., 1918, XIX, No. 2.

This hospital was established through the efforts of Mr. Rockefeller, Jr. A tract of land adjoining the New York State Reformatory was purchased, and a building capable of accommodating fifty inmates and a staff of eleven persons was erected. The hospital receives every woman committed to the State Reformatory. Its purpose is the intensive study of criminal women who show an abnormal mentality, but who cannot be considered insane. The laboratory maintains three departments. The department of sociology makes a thorough investigation of the social history of each patient, including her heredity, environment, etc. The department of psychology chiefly applies mental tests. The department of psychiatry carries out the scientific study of psychopathic cases and experiments with the various methods of treatment.



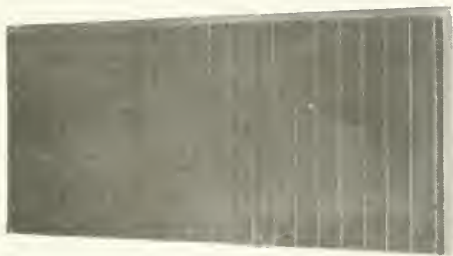
VINCENZ MUELLER, Technical Editor.
GEO. W. WALLERICH, Associate Editor.

Please address items of news and inquiries regarding New Instruments and Appliances to the editor of this department, 327 Southeast Avenue, Oak Park, Illinois.

Light-Proof Dark-Room Ventilators

The lack of ventilation in the ordinary laboratory dark-room has long been a serious question. In the majority of instances the developing room or, as ordinarily called, dark-room, is simply a makeshift, an ordinary room with close-fitting door, windows securely fastened and painted black, and without ventilation, except such as is obtained by the infrequent opening of the door. As a result roentgenographers and their technicians have been forced to work under most insanitary as well as unsavory conditions, greatly impairing their efficiency. This condition has been due not so much to inattention as to the difficulty in obtaining proper ventilation and at the same time preventing the admission of light.

A comparatively recent invention, however, seems to have solved the question satisfactorily. The Freyberg Light-Proof Dark-Room Ventilators are designed to provide ventilation in Roentgen operating rooms, developing rooms, or other places where ventilation is desired with the positive exclusion of light. These ventilators were designed after long experiments and have proved very satisfactory for the purpose for which they are intended. They are made of sheet metal in the form of a rectangular box enclosing the series of vertically arranged planes set parallel to each other with air passages between. These planes are irregularly zigzagged at angles properly determined to nullify reflection, thereby completely excluding both direct and reflected light within the air pas-



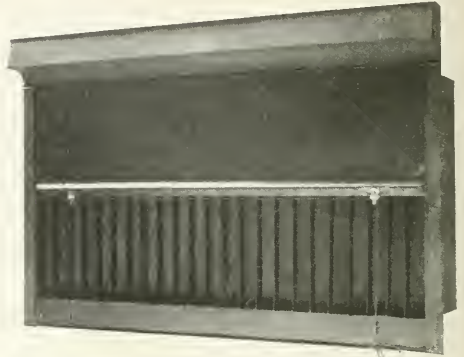
Plain light-proof dark-room ventilator

sages and yet providing ventilation. Total absence of light with a ventilating area of 65 percent of the horizontal dimension by the full height of the ventilator is the result.

The ventilators are made in two styles, one plain, for

use in interior partitions or where it is not necessary to control the amount of ventilation, and the other style which is the same as the plain, but fitted with a Pantasote spring roller shade in a separate frame attached to the ventilator for controlling the ventilation when installed in an opening communicating with the open air.

A very satisfactory arrangement is for the installation of the ventilator on the outside of the lower sash of a window. This permits the use of the upper sash for ordinary purposes and also makes possible the use of the lower sash to control the amount of ventilation desired.



Light-proof dark-room ventilator showing shade control partly closed

Another method is to install the ventilator in an existing window opening parallel to the upper sash. This will permit the ordinary use of the lower sash while the upper sash when pulled down makes the ventilation effective.

Owing to the fact that these ventilators must be constructed to meet individual requirements they are made to order only. They are frequently installed in pairs, one in an interior passage partition and the other opposite an opening to the open air to promote air circulation.

The Hygienic Work of the Anti-tuberculosis Dispensaries

The function of tuberculosis dispensaries is not so much to treat tuberculous patients as to prevent the disease, especially among the young people and the children. Their chief work consists in education and propaganda, which will furnish the people defensive arms against a disease which hospitals and sanatoriums try in vain to combat. This does not mean that the dispensaries should give up entirely the treatment of patients, for they are a valuable aid to the sanatoriums; but it is their supreme duty in the highest interest of the nation to prevent sound persons from falling prey to the disease. In the present state of therapeutics the successful struggle with tuberculosis depends chiefly on prophylaxis. Of great importance are domiciliary visits of the physicians and specially trained nurses who at regular intervals see the families of patients, study their needs, comfort them and teach them how to prevent the spread of the disease. Every dispensary should at certain periods put up posters in prominent places (schools, hospitals, churches, theaters) calling attention to its existence and its purpose. A small booklet containing information regarding the disease and advice how to prevent it should be handed to all visitors, says D. Ottolenghi, writing in *Igiene Moderna* of Genoa.

PA The Modern hospital
960
M7
v.11
cop.2

Biological
& Medical
Serials

PLEASE DO NOT REMOVE
CARDS OR SLIPS FROM THIS POCKET

UNIVERSITY OF TORONTO LIBRARY
